

Medi-Cal Base Policy Changes

The Medi-Cal base estimate consists of projections of expenditures based on recent trends of actual data. The base estimate does not include the impact of future program changes, which are added to the base estimate through regular policy changes as displayed in the Regular Policy Change section.

The base estimate consists of two types. The first type, the Fee-for-Service Base Estimate, is described and summarized in the previous section (FFS Base).

The second type of base estimate, which had traditionally been called the Non-Fee-for-Service (Non-FFS) Base Estimate, is displayed in this section. Because some of these base estimates include services paid on a fee-for-service basis, that name is technically not correct. As a result, this second type of base estimate will be called Base Policy Changes because as in the past they are entered into the Medi-Cal Estimate and displayed using the policy change format. These Base Policy Changes form the base estimates for the last 14 service categories (Managed Care through Drug Medi-Cal) as displayed in most tables throughout this binder and listed below. The data used for these projections come from a variety of sources, such as other claims processing systems, managed care enrollments, and other payment data. Also, some of the projections in this group come directly from other State departments.

Base Policy Change Service Categories:

Two Plan Model
County Organized Health Systems
Geographic Managed Care
PHP & Other Managed Care (Other M/C)
Regional Model
Dental
Mental Health
Audits/Lawsuits
EPSDT Screens
Medicare Payments
State Hospital/Developmental Centers
Miscellaneous Services (Misc. Svcs.)
Recoveries
Drug Medi-Cal

**SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2015-16**

<u>POLICY CHG. NO.</u>	<u>CATEGORY & TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>STATE FUNDS</u>
<u>ELIGIBILITY</u>				
4	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	\$67,673,000	\$48,581,000	\$19,092,000
8	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL	\$12,715,000	\$10,018,960	\$2,696,040
	ELIGIBILITY SUBTOTAL	\$80,388,000	\$58,599,960	\$21,788,040
<u>DRUG MEDI-CAL</u>				
63	NARCOTIC TREATMENT PROGRAM	\$93,397,000	\$93,397,000	\$0
64	INTENSIVE OUTPATIENT TREATMENT SERVICES	\$32,632,000	\$20,339,000	\$12,293,000
66	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$14,495,000	\$14,495,000	\$0
67	RESIDENTIAL TREATMENT SERVICES	\$5,162,000	\$5,162,000	\$0
	DRUG MEDI-CAL SUBTOTAL	\$145,686,000	\$133,393,000	\$12,293,000
<u>MENTAL HEALTH</u>				
70	SMHS FOR ADULTS	\$909,985,000	\$839,574,000	\$70,411,000
71	SMHS FOR CHILDREN	\$1,016,690,000	\$974,791,000	\$41,899,000
	MENTAL HEALTH SUBTOTAL	\$1,926,675,000	\$1,814,365,000	\$112,310,000
<u>MANAGED CARE</u>				
105	TWO PLAN MODEL	\$20,052,924,000	\$14,829,759,030	\$5,223,164,970
106	COUNTY ORGANIZED HEALTH SYSTEMS	\$8,353,031,000	\$6,197,000,560	\$2,156,030,440
107	GEOGRAPHIC MANAGED CARE	\$3,441,331,000	\$2,538,499,740	\$902,831,260
110	REGIONAL MODEL	\$1,309,989,000	\$969,629,560	\$340,359,440
114	PACE (Other M/C)	\$294,166,000	\$147,083,000	\$147,083,000
116	DENTAL MANAGED CARE (Other M/C)	\$144,027,000	\$87,601,860	\$56,425,140
117	SENIOR CARE ACTION NETWORK (Other M/C)	\$60,948,000	\$30,474,000	\$30,474,000
120	AIDS HEALTHCARE CENTERS (Other M/C)	\$7,405,000	\$3,702,500	\$3,702,500
122	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$913,000	\$456,500	\$456,500
	MANAGED CARE SUBTOTAL	\$33,664,734,000	\$24,804,206,750	\$8,860,527,250
<u>OTHER</u>				
164	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$2,649,830,000	\$1,218,687,000	\$1,431,143,000
165	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$1,661,965,000	\$0	\$1,661,965,000
166	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	\$1,708,743,000	\$1,708,743,000	\$0
167	DENTAL SERVICES	\$1,014,022,000	\$660,641,610	\$353,380,390
168	PERSONAL CARE SERVICES (Misc. Svcs.)	\$1,086,867,000	\$1,086,867,000	\$0
169	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$206,129,000	\$206,129,000	\$0
171	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$188,380,000	\$188,380,000	\$0
175	MEDI-CAL TCM PROGRAM	\$43,872,000	\$43,872,000	\$0
176	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$40,250,000	\$20,125,000	\$20,125,000
177	EPSDT SCREENS	\$38,271,000	\$19,523,850	\$18,747,150
183	LAWSUITS/CLAIMS	\$3,370,000	\$1,663,000	\$1,707,000
184	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$2,216,000	\$1,108,000	\$1,108,000

**SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2015-16**

<u>POLICY CHG. NO.</u>	<u>CATEGORY & TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>STATE FUNDS</u>
	OTHER			
185	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,537,000	\$1,537,000	\$0
197	BASE RECOVERIES	<u>-\$306,727,000</u>	<u>-\$146,274,000</u>	<u>-\$160,453,000</u>
	OTHER SUBTOTAL	\$8,338,725,000	\$5,011,002,460	\$3,327,722,540
	GRAND TOTAL	<u><u>\$44,156,208,000</u></u>	<u><u>\$31,821,567,170</u></u>	<u><u>\$12,334,640,830</u></u>

SUMMARY OF BASE POLICY CHANGES FISCAL YEAR 2016-17

POLICY CHG. NO.	CATEGORY & TITLE	TOTAL FUNDS	FEDERAL FUNDS	STATE FUNDS
ELIGIBILITY				
4	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL	\$62,379,000	\$50,094,000	\$12,285,000
8	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL	\$11,701,000	\$10,296,880	\$1,404,120
	ELIGIBILITY SUBTOTAL	\$74,080,000	\$60,390,880	\$13,689,120
DRUG MEDI-CAL				
63	NARCOTIC TREATMENT PROGRAM	\$96,629,000	\$96,207,700	\$421,300
64	INTENSIVE OUTPATIENT TREATMENT SERVICES	\$29,194,000	\$16,550,100	\$12,643,900
66	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$14,617,000	\$14,495,900	\$121,100
67	RESIDENTIAL TREATMENT SERVICES	\$5,745,000	\$5,745,000	\$0
	DRUG MEDI-CAL SUBTOTAL	\$146,185,000	\$132,998,700	\$13,186,300
MENTAL HEALTH				
70	SMHS FOR ADULTS	\$897,363,000	\$820,307,200	\$77,055,800
71	SMHS FOR CHILDREN	\$1,090,478,000	\$1,046,311,000	\$44,167,000
	MENTAL HEALTH SUBTOTAL	\$1,987,841,000	\$1,866,618,200	\$121,222,800
MANAGED CARE				
105	TWO PLAN MODEL	\$18,469,452,000	\$12,909,667,440	\$5,559,784,560
106	COUNTY ORGANIZED HEALTH SYSTEMS	\$7,458,135,000	\$5,302,771,040	\$2,155,363,960
107	GEOGRAPHIC MANAGED CARE	\$3,408,128,000	\$2,439,562,240	\$968,565,760
110	REGIONAL MODEL	\$1,231,722,000	\$878,197,200	\$353,524,800
114	PACE (Other M/C)	\$322,812,000	\$161,406,000	\$161,406,000
116	DENTAL MANAGED CARE (Other M/C)	\$147,449,000	\$89,215,010	\$58,233,990
117	SENIOR CARE ACTION NETWORK (Other M/C)	\$74,169,000	\$37,084,500	\$37,084,500
120	AIDS HEALTHCARE CENTERS (Other M/C)	\$7,405,000	\$3,702,500	\$3,702,500
122	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$913,000	\$456,500	\$456,500
	MANAGED CARE SUBTOTAL	\$31,120,185,000	\$21,822,062,430	\$9,298,122,570
OTHER				
164	MEDICARE PMNTS. - BUY-IN PART A & B PREMIUMS	\$2,703,855,000	\$1,243,870,500	\$1,459,984,500
165	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$1,871,377,000	\$0	\$1,871,377,000
166	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	\$1,535,667,000	\$1,535,667,000	\$0
167	DENTAL SERVICES	\$1,140,954,000	\$741,058,830	\$399,895,170
168	PERSONAL CARE SERVICES (Misc. Svcs.)	\$1,493,950,000	\$1,493,950,000	\$0
169	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$207,330,000	\$207,330,000	\$0
171	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$161,949,000	\$161,949,000	\$0
175	MEDI-CAL TCM PROGRAM	\$39,634,000	\$39,634,000	\$0
176	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$41,545,000	\$20,772,500	\$20,772,500
177	EPSDT SCREENS	\$38,271,000	\$19,523,850	\$18,747,150
183	LAWSUITS/CLAIMS	\$1,865,000	\$932,500	\$932,500
184	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$2,283,000	\$1,141,500	\$1,141,500

**SUMMARY OF BASE POLICY CHANGES
FISCAL YEAR 2016-17**

<u>POLICY CHG. NO.</u>	<u>CATEGORY & TITLE</u>	<u>TOTAL FUNDS</u>	<u>FEDERAL FUNDS</u>	<u>STATE FUNDS</u>
	OTHER			
185	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,028,000	\$1,028,000	\$0
197	BASE RECOVERIES	-\$289,203,000	-\$137,917,000	-\$151,286,000
	OTHER SUBTOTAL	\$8,950,505,000	\$5,328,940,680	\$3,621,564,320
	GRAND TOTAL	\$42,278,796,000	\$29,211,010,890	\$13,067,785,110

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
NOVEMBER 2015 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2015-16**

NO.	POLICY CHANGE TITLE	2015-16 APPROPRIATION		NOV. 2015 EST. FOR 2015-16		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
ELIGIBILITY							
4	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPI	\$93,271,000	\$38,806,000	\$67,673,000	\$19,092,000	-\$25,598,000	-\$19,714,000
8	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL	\$16,482,000	\$5,768,700	\$12,715,000	\$2,696,040	-\$3,767,000	-\$3,072,660
	ELIGIBILITY SUBTOTAL	\$109,753,000	\$44,574,700	\$80,388,000	\$21,788,040	-\$29,365,000	-\$22,786,660
DRUG MEDI-CAL							
63	NARCOTIC TREATMENT PROGRAM	\$85,534,000	\$0	\$93,397,000	\$0	\$7,863,000	\$0
64	INTENSIVE OUTPATIENT TREATMENT SERVICES	\$40,057,000	\$12,424,000	\$32,632,000	\$12,293,000	-\$7,425,000	-\$131,000
66	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$20,779,000	\$0	\$14,495,000	\$0	-\$6,284,000	\$0
67	RESIDENTIAL TREATMENT SERVICES	\$33,618,000	\$9,832,000	\$5,162,000	\$0	-\$28,456,000	-\$9,832,000
	DRUG MEDI-CAL SUBTOTAL	\$179,988,000	\$22,256,000	\$145,686,000	\$12,293,000	-\$34,302,000	-\$9,963,000
MENTAL HEALTH							
70	SMHS FOR ADULTS	\$1,149,581,000	\$68,885,000	\$909,985,000	\$70,411,000	-\$239,596,000	\$1,526,000
71	SMHS FOR CHILDREN	\$992,419,000	\$43,095,000	\$1,016,690,000	\$41,899,000	\$24,271,000	-\$1,196,000
	MENTAL HEALTH SUBTOTAL	\$2,142,000,000	\$111,980,000	\$1,926,675,000	\$112,310,000	-\$215,325,000	\$330,000
MANAGED CARE							
105	TWO PLAN MODEL	\$10,518,318,000	\$5,119,314,000	\$20,052,924,000	\$5,223,164,970	\$9,534,606,000	\$103,850,970
106	COUNTY ORGANIZED HEALTH SYSTEMS	\$4,589,386,000	\$2,221,705,300	\$8,353,031,000	\$2,156,030,440	\$3,763,645,000	-\$65,674,860
107	GEOGRAPHIC MANAGED CARE	\$2,050,257,000	\$994,887,900	\$3,441,331,000	\$902,831,260	\$1,391,074,000	-\$92,056,640
110	REGIONAL MODEL	\$750,730,000	\$365,171,550	\$1,309,989,000	\$340,359,440	\$559,259,000	-\$24,812,110
114	PACE (Other M/C)	\$295,935,000	\$147,967,500	\$294,166,000	\$147,083,000	-\$1,769,000	-\$884,500
116	DENTAL MANAGED CARE (Other M/C)	\$146,820,000	\$60,779,700	\$144,027,000	\$56,425,140	-\$2,793,000	-\$4,354,560
117	SENIOR CARE ACTION NETWORK (Other M/C)	\$47,202,000	\$23,601,000	\$60,948,000	\$30,474,000	\$13,746,000	\$6,873,000
120	AIDS HEALTHCARE CENTERS (Other M/C)	\$7,003,000	\$3,501,500	\$7,405,000	\$3,702,500	\$402,000	\$201,000
122	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$976,000	\$488,000	\$913,000	\$456,500	-\$63,000	-\$31,500
	MANAGED CARE SUBTOTAL	\$18,406,627,000	\$8,937,416,450	\$33,664,734,000	\$8,860,527,250	\$15,258,107,000	-\$76,889,200
OTHER							
164	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$2,618,021,000	\$1,408,764,500	\$2,649,830,000	\$1,431,143,000	\$31,809,000	\$22,378,500
165	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$1,636,699,000	\$1,636,699,000	\$1,661,965,000	\$1,661,965,000	\$25,266,000	\$25,266,000
166	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	\$1,541,478,000	\$0	\$1,708,743,000	\$0	\$167,265,000	\$0

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
NOVEMBER 2015 ESTIMATE COMPARED TO APPROPRIATION
FISCAL YEAR 2015-16**

NO.	POLICY CHANGE TITLE	2015-16 APPROPRIATION		NOV. 2015 EST. FOR 2015-16		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
OTHER							
167	DENTAL SERVICES	\$1,101,822,000	\$428,145,500	\$1,014,022,000	\$353,380,390	-\$87,800,000	-\$74,765,110
168	PERSONAL CARE SERVICES (Misc. Svcs.)	\$845,295,000	\$0	\$1,086,867,000	\$0	\$241,572,000	\$0
169	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$206,500,000	\$0	\$206,129,000	\$0	-\$371,000	\$0
171	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$162,286,000	\$0	\$188,380,000	\$0	\$26,094,000	\$0
175	MEDI-CAL TCM PROGRAM	\$47,090,000	\$0	\$43,872,000	\$0	-\$3,218,000	\$0
176	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$44,659,000	\$22,329,500	\$40,250,000	\$20,125,000	-\$4,409,000	-\$2,204,500
177	EPSDT SCREENS	\$38,736,000	\$18,901,500	\$38,271,000	\$18,747,150	-\$465,000	-\$154,350
183	LAWSUITS/CLAIMS	\$3,690,000	\$1,845,000	\$3,370,000	\$1,707,000	-\$320,000	-\$138,000
184	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$2,152,000	\$1,076,000	\$2,216,000	\$1,108,000	\$64,000	\$32,000
185	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,285,000	\$0	\$1,537,000	\$0	\$252,000	\$0
197	BASE RECOVERIES	-\$277,433,000	-\$139,644,000	-\$306,727,000	-\$160,453,000	-\$29,294,000	-\$20,809,000
	OTHER SUBTOTAL	\$7,972,280,000	\$3,378,117,000	\$8,338,725,000	\$3,327,722,540	\$366,445,000	-\$50,394,460
	GRAND TOTAL	\$28,810,648,000	\$12,494,344,150	\$44,156,208,000	\$12,334,640,830	\$15,345,560,000	-\$159,703,320

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2015-16 AND 2016-17**

NO.	POLICY CHANGE TITLE	NOV. 2015 EST. FOR 2015-16		NOV. 2015 EST. FOR 2016-17		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
ELIGIBILITY							
4	MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% F	\$67,673,000	\$19,092,000	\$62,379,000	\$12,285,000	-\$5,294,000	-\$6,807,000
8	MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL	\$12,715,000	\$2,696,040	\$11,701,000	\$1,404,120	-\$1,014,000	-\$1,291,920
	ELIGIBILITY SUBTOTAL	\$80,388,000	\$21,788,040	\$74,080,000	\$13,689,120	-\$6,308,000	-\$8,098,920
DRUG MEDI-CAL							
63	NARCOTIC TREATMENT PROGRAM	\$93,397,000	\$0	\$96,629,000	\$421,300	\$3,232,000	\$421,300
64	INTENSIVE OUTPATIENT TREATMENT SERVICES	\$32,632,000	\$12,293,000	\$29,194,000	\$12,643,900	-\$3,438,000	\$350,900
66	OUTPATIENT DRUG FREE TREATMENT SERVICES	\$14,495,000	\$0	\$14,617,000	\$121,100	\$122,000	\$121,100
67	RESIDENTIAL TREATMENT SERVICES	\$5,162,000	\$0	\$5,745,000	\$0	\$583,000	\$0
	DRUG MEDI-CAL SUBTOTAL	\$145,686,000	\$12,293,000	\$146,185,000	\$13,186,300	\$499,000	\$893,300
MENTAL HEALTH							
70	SMHS FOR ADULTS	\$909,985,000	\$70,411,000	\$897,363,000	\$77,055,800	-\$12,622,000	\$6,644,800
71	SMHS FOR CHILDREN	\$1,016,690,000	\$41,899,000	\$1,090,478,000	\$44,167,000	\$73,788,000	\$2,268,000
	MENTAL HEALTH SUBTOTAL	\$1,926,675,000	\$112,310,000	\$1,987,841,000	\$121,222,800	\$61,166,000	\$8,912,800
MANAGED CARE							
105	TWO PLAN MODEL	\$20,052,924,000	\$5,223,164,970	\$18,469,452,000	\$5,559,784,560	-\$1,583,472,000	\$336,619,590
106	COUNTY ORGANIZED HEALTH SYSTEMS	\$8,353,031,000	\$2,156,030,440	\$7,458,135,000	\$2,155,363,960	-\$894,896,000	-\$666,480
107	GEOGRAPHIC MANAGED CARE	\$3,441,331,000	\$902,831,260	\$3,408,128,000	\$968,565,760	-\$33,203,000	\$65,734,500
110	REGIONAL MODEL	\$1,309,989,000	\$340,359,440	\$1,231,722,000	\$353,524,800	-\$78,267,000	\$13,165,360
114	PACE (Other M/C)	\$294,166,000	\$147,083,000	\$322,812,000	\$161,406,000	\$28,646,000	\$14,323,000
116	DENTAL MANAGED CARE (Other M/C)	\$144,027,000	\$56,425,140	\$147,449,000	\$58,233,990	\$3,422,000	\$1,808,850
117	SENIOR CARE ACTION NETWORK (Other M/C)	\$60,948,000	\$30,474,000	\$74,169,000	\$37,084,500	\$13,221,000	\$6,610,500
120	AIDS HEALTHCARE CENTERS (Other M/C)	\$7,405,000	\$3,702,500	\$7,405,000	\$3,702,500	\$0	\$0
122	FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)	\$913,000	\$456,500	\$913,000	\$456,500	\$0	\$0
	MANAGED CARE SUBTOTAL	\$33,664,734,000	\$8,860,527,250	\$31,120,185,000	\$9,298,122,570	-\$2,544,549,000	\$437,595,320
OTHER							
164	MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS	\$2,649,830,000	\$1,431,143,000	\$2,703,855,000	\$1,459,984,500	\$54,025,000	\$28,841,500

Costs shown include application of payment lag factor, but not percent reflected in base calculation.

**COMPARISON OF FISCAL IMPACTS OF BASE POLICY CHANGES
CURRENT YEAR COMPARED TO BUDGET YEAR
FISCAL YEARS 2015-16 AND 2016-17**

NO.	POLICY CHANGE TITLE	NOV. 2015 EST. FOR 2015-16		NOV. 2015 EST. FOR 2016-17		DIFFERENCE	
		TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS	TOTAL FUNDS	STATE FUNDS
OTHER							
165	MEDICARE PAYMENTS - PART D PHASED-DOWN	\$1,661,965,000	\$1,661,965,000	\$1,871,377,000	\$1,871,377,000	\$209,412,000	\$209,412,000
166	HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)	\$1,708,743,000	\$0	\$1,535,667,000	\$0	-\$173,076,000	\$0
167	DENTAL SERVICES	\$1,014,022,000	\$353,380,390	\$1,140,954,000	\$399,895,170	\$126,932,000	\$46,514,780
168	PERSONAL CARE SERVICES (Misc. Svcs.)	\$1,086,867,000	\$0	\$1,493,950,000	\$0	\$407,083,000	\$0
169	DEVELOPMENTAL CENTERS/STATE OP SMALL FAC	\$206,129,000	\$0	\$207,330,000	\$0	\$1,201,000	\$0
171	TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)	\$188,380,000	\$0	\$161,949,000	\$0	-\$26,431,000	\$0
175	MEDI-CAL TCM PROGRAM	\$43,872,000	\$0	\$39,634,000	\$0	-\$4,238,000	\$0
176	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)	\$40,250,000	\$20,125,000	\$41,545,000	\$20,772,500	\$1,295,000	\$647,500
177	EPSDT SCREENS	\$38,271,000	\$18,747,150	\$38,271,000	\$18,747,150	\$0	\$0
183	LAWSUITS/CLAIMS	\$3,370,000	\$1,707,000	\$1,865,000	\$932,500	-\$1,505,000	-\$774,500
184	HIPP PREMIUM PAYOUTS (Misc. Svcs.)	\$2,216,000	\$1,108,000	\$2,283,000	\$1,141,500	\$67,000	\$33,500
185	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)	\$1,537,000	\$0	\$1,028,000	\$0	-\$509,000	\$0
197	BASE RECOVERIES	-\$306,727,000	-\$160,453,000	-\$289,203,000	-\$151,286,000	\$17,524,000	\$9,167,000
	OTHER SUBTOTAL	\$8,338,725,000	\$3,327,722,540	\$8,950,505,000	\$3,621,564,320	\$611,780,000	\$293,841,780
	GRAND TOTAL	\$44,156,208,000	\$12,334,640,830	\$42,278,796,000	\$13,067,785,110	-\$1,877,412,000	\$733,144,280

Costs shown include application of payment lag factor, but not percent reflected in base calculation.

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**MEDI-CAL PROGRAM BASE
POLICY CHANGE INDEX**

POLICY CHANGE NUMBER	POLICY CHANGE TITLE
	OTHER
176	WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)
177	EPSDT SCREENS
183	LAWSUITS/CLAIMS
184	HIPP PREMIUM PAYOUTS (Misc. Svcs.)
185	CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)
197	BASE RECOVERIES

MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL

BASE POLICY CHANGE NUMBER: 4
IMPLEMENTATION DATE: 7/2014
ANALYST: Ryan Witz
FISCAL REFERENCE NUMBER: 1837

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	\$67,673,000	\$62,379,000
- STATE FUNDS	\$19,092,000	\$12,285,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$67,673,000	\$62,379,000
STATE FUNDS	\$19,092,000	\$12,285,000
FEDERAL FUNDS	\$48,581,000	\$50,094,000

DESCRIPTION

Purpose:

This policy change estimates the benefits cost for the Medi-Cal Access Program (MCAP) mothers with incomes between 213-322% of the federal poverty level (FPL).

Authority:

AB 99 (Chapter 278, Statutes of 1991)
 SB 800 (Chapter 448, Statutes of 2013)

Interdependent Policy Changes:

PC 8 Medi-Cal Access Program Infants 266-322% FPL

Background:

Effective July 1, 2014, the Access for Infants and Mothers Program (AIM) was transitioned and renamed MCAP. The MCAP covers pregnant women in families with incomes between 213-322% FPL. These pregnant women are subject to premiums fixed at 1.5% of their adjusted annual income.

Reason for Change from Prior Estimate:

- The May 2015 estimate assumed a monthly average of 3,774 pregnant women for FY 2015-16. Based on actual enrollment data through June 2015, the November 2015 estimate assumes a monthly average of 3,534 pregnant women for FY 2015-16 and 3,085 for FY 2016-17.
- June 2016 estimated capitation payments moved to FY 2016-17.
- Due to the timing of when June 2017 estimated capitation payments are received, they are assumed to be paid in FY 2017-18.

Methodology:

1) Based on actual enrollment data from September 2012 through January 2015, the Department estimates the following:

	FY 2015-16	FY 2016-17
Average monthly caseload	3,534	3,085
Deliveries	431	382

MEDI-CAL ACCESS PROGRAM MOTHERS 213-322% FPL

BASE POLICY CHANGE NUMBER: 4

- 2) The Department estimates the following PMPM and PMPD costs:

	FY 2015-16	FY 2016-17
PMPM: July-Sept 2014	\$493.37	
PMPM: Oct-Sept 2015	\$495.83	\$495.83
PMPD: July-Sept 2014	\$10,204.10	
PMPD: Oct-Sept 2015	\$11,582.93	\$11,582.93

- 3) Medi-Cal Access Program subscribers are subject to premiums fixed at 1.5% of their adjusted annual income. Premiums are estimated to total \$3,639,000 in both FY 2015-16 and FY 2015-16.
- 4) The Department assumes 10% of the monthly subscribers have a maternity only deductible exceeding \$500 and are ineligible for FFP.
- 5) The total estimated costs for the Medi-Cal Access Program mothers in FY 2015-16 and FY 2016-17 are:

(Dollars in Thousands)

FY 2015-16	TF	SF	FF
65% Title XXI FFP/35% Perinatal Insurance Fund	\$24,777	\$8,672	\$16,105
88% Title XXI FFP/12% Perinatal Insurance Fund	\$39,324	\$4,719	\$34,605
100% Perinatal Insurance Fund	\$7,211	\$7,211	\$0
Premiums	(\$3,639)	(\$1,510)	(\$2,129)
Total	\$67,673	\$19,092	\$48,581

(Dollars in Thousands)

FY 2016-17	TF	SF	FF
88% Title XXI FFP/12% Perinatal Insurance Fund	\$59,344	\$7,121	\$52,223
100% Perinatal Insurance Fund	\$6,674	\$6,674	\$0
Premiums	(\$3,639)	(\$1,510)	(\$2,129)
Total	\$62,379	\$12,285	\$50,094

Funding:

Perinatal Insurance Fund (4260-602-0309)

Title XXI FFP (4260-113-0890)

MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL

BASE POLICY CHANGE NUMBER: 8
IMPLEMENTATION DATE: 11/2013
ANALYST: Ryan Witz
FISCAL REFERENCE NUMBER: 1797

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	\$12,715,000	\$11,701,000
- STATE FUNDS	\$2,696,040	\$1,404,120
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$12,715,000	\$11,701,000
STATE FUNDS	\$2,696,040	\$1,404,120
FEDERAL FUNDS	\$10,018,960	\$10,296,880

DESCRIPTION

Purpose:

This policy change estimates the benefits cost for the Medi-Cal Access Program (MCAP) linked infants with incomes between 266-322% of the federal poverty level (FPL).

Authority:

AB 82 (Chapter 23, Statutes of 2013)

Interdependent Policy Changes:

Not Applicable

Background:

Effective November 1, 2013, MCAP linked infants transitioned into the Medi-Cal delivery system through a phase-in methodology. These infants are born to the women enrolled in the Medi-Cal Access Program. Similar to subscribers enrolled in the Optional Targeted Low Income Children's Program (OTLICP) with incomes above 150% of the FPL, subscribers enrolled in MCAP are subject to premiums.

Reason for Change from Prior Estimate:

Updated enrollment projections reflect a 41% decrease of 1st and 2nd year infants in FY 2015-16. This is based upon updated enrollment projections from PC 4 MCAP Mothers 213-322% FPL.

Methodology:

1. The Department estimates 3,349 average monthly infants with family income between 266% and 322% FPL will enroll in FY 2015-16 and 2,594 in FY 2016-17.
2. The Department estimates the weighted average monthly per-member-per-month (PMPM) cost in FY 2015-16 is \$342.39 and \$388.83 in FY 2016-17. The increase from FY 2015-16 to FY 2016-17 is due to an increase in the number of infants calculated at the first two-month infant rate.
3. MCAP subscribers are subject to monthly premiums. Premiums are estimated to total \$522,000 in FY 2015-16 and \$405,000 in FY 2016-17.

MEDI-CAL ACCESS PROGRAM INFANTS 266-322% FPL**BASE POLICY CHANGE NUMBER: 8**

4. The increased number of enrolled pregnant mothers will also have direct correlation to the increased number of enrolled linked infants into the Medi-Cal Infant Access Program and OTLICP.
5. The total estimated costs for the MCAP linked infants in FY 2015-16 and FY 2016-17 are:

(Dollars in thousands)	FY 2015-16		FY 2016-17	
	TF	GF	TF	GF
Benefits	\$13,237	\$2,807	\$12,105	\$1,453
Premiums	(\$522)	(\$111)	(\$405)	(\$49)
Net	\$12,715	\$2,696	\$11,701	\$1,404

Funding:

65% Title XXI FFP/35% GF (4260-113-0890/0001)

88% Title XXI FFP/12% GF (4260-113-0890/0001)

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 63
IMPLEMENTATION DATE: 7/2012
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1728

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	\$93,397,000	\$96,629,000
- STATE FUNDS	\$0	\$421,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$93,397,000	\$96,629,000
STATE FUNDS	\$0	\$421,300
FEDERAL FUNDS	\$93,397,000	\$96,207,700

DESCRIPTION

Purpose:

This policy change estimates the federal reimbursement funds for the Drug Medi-Cal (DMC), Narcotic Treatment Program's (NTP) daily methadone dosing and counseling services.

Authority:

Title 22, California Code of Regulations 51341.1 (b)(17); 51341.1 (d)(1); 51516.1 (b)

Interdependent Policy Changes:

Not Applicable

Background:

The NTP provides outpatient methadone maintenance services directed at stabilization and rehabilitation of persons with opioid dependency and substance use disorder diagnoses. The program includes daily medication dosing, a medical evaluation, treatment planning, and a minimum of fifty minutes per month of face-to-face counseling sessions.

The DMC program provides certain medically necessary substance use disorder treatment services. These services are provided by certified providers under contract with the counties or with the State. Funding for the services is 50% CF and 50% Title XIX federal funds (FF). Certain aid codes are eligible for Title XXI federal reimbursement at 65% and 88%. ACA Optional Expansion population is eligible for Title XIX federal reimbursement at 100% until December 2016 and 95% beginning January 2017.

Reason for Change from Prior Estimate:

The reasons for change are due to updated caseload, rates and units of service (UOS) for the regular and perinatal populations.

Methodology:

1. The caseload projections are based on complete caseload data from January 2010 through March 2015.
2. The UOS is based on the total approved units divided by the caseload. Complete data from July

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 63

2013 through June 2014 was used to calculate the average UOS.

3. The proposed DMC rates are based on the developed rates or the FY 2009-10 Budget Act rates adjusted for the cumulative growth in the Implicit Price (CIP) Deflator for the Cost of Goods and Services to Governmental Agencies reported by Department of Finance, whichever is lower. FY 2015-16 and FY 2016-17 budgeted amounts are based on the FY 2015-16 rates. For more information about the FY 2016-17 rates, see the Annual Rate Adjustment policy change.
4. The cost estimate is developed by the following: UOS x Rates x Caseload.

FY 2015-16	UOS	Rates	Caseload	Total
Regular				
Dosing	210.4	\$11.44	43,075	\$103,681,000
Individual	92.9	\$13.39	43,075	\$53,583,000
Group	0.3	\$3.02	43,075	\$39,000
EPSDT				
Dosing	116.0	\$11.44	406	\$539,000
Individual	58.5	\$13.39	406	\$318,000
Group	0.1	\$3.02	406	\$0
ACA Optional				
Dosing	210.4	\$11.44	4,600	\$11,071,000
Individual	92.9	\$13.39	4,600	\$5,722,000
Group	0.3	\$3.02	4,600	\$4,000
Total				\$174,957,000
Perinatal				
Dosing	101.1	\$13.72	204	\$282,000
Individual	41.2	\$21.40	204	\$180,000
Group	0.2	\$5.79	204	\$0
ACA Optional				
Dosing	101.1	\$13.72	22	\$31,000
Individual	41.2	\$21.40	22	\$20,000
Group	0.2	\$5.79	22	\$0
Total				\$513,000

NARCOTIC TREATMENT PROGRAM

BASE POLICY CHANGE NUMBER: 63

FY 2016-17	UOS	Rates	Caseload	Total
Regular				
Dosing	210.4	\$11.44	43,075	\$103,681,000
Individual	92.9	\$13.39	43,075	\$53,583,000
Group	0.3	\$3.02	43,075	\$39,000
EPSDT				
Dosing	116.0	\$11.44	423	\$561,000
Individual	58.5	\$13.39	423	\$331,000
Group	0.1	\$3.02	423	\$0
ACA Optional				
Dosing	210.4	\$11.44	4,600	\$11,071,000
Individual	92.9	\$13.39	4,600	\$5,722,000
Group	0.3	\$3.02	4,600	\$4,000
Total				\$174,992,000
Perinatal				
Dosing	101.1	\$13.72	219	\$304,000
Individual	41.2	\$21.40	219	\$193,000
Group	0.2	\$5.79	219	\$0
ACA Optional				
Dosing	101.1	\$13.72	24	\$33,000
Individual	41.2	\$21.40	24	\$21,000
Group	0.2	\$5.79	24	\$0
Total				\$551,000

5. Based on historical claims received, assume 75% of each fiscal year claims will be paid in the year the services occurred. The remaining 25% will be paid in the following year.

	Accrual	FY 2015-16	FY 2016-17
FY 2014-15			
Regular	\$152,457,000	\$38,114,000	\$0
Perinatal	\$472,000	\$118,000	\$0
FY 2015-16			
Regular	\$174,957,000	\$131,218,000	\$43,739,000
Perinatal	\$513,000	\$385,000	\$128,000
FY 2016-17			
Regular	\$174,992,000	\$0	\$131,245,000
Perinatal	\$551,000	\$0	\$414,000
		\$169,835,000	\$175,526,000

NARCOTIC TREATMENT PROGRAM**BASE POLICY CHANGE NUMBER: 63**

6. Total estimated federal reimbursements for NTP services are:

FY 2015-16	TF	FF (Title XIX)	FF (Title XXI)	County	GF
Regular	\$153,133,000	\$76,100,000	\$753,000	\$76,280,000	\$0
Regular - ACA Optional 100%	\$16,201,000	\$16,201,000	\$0	\$0	\$0
Perinatal	\$452,000	\$0	\$294,000	\$158,000	\$0
Perinatal - ACA Optional 100%	\$49,000	\$49,000	\$0	\$0	\$0
Total	\$169,835,000	\$92,350,000	\$1,047,000	\$76,438,000	\$0

FY 2016-17	TF	FF (Title XIX)	FF (Title XXI)	County	GF
Regular	\$158,186,000	\$78,683,000	\$778,000	\$78,725,000	\$0
Regular - ACA Optional 100%	\$8,399,000	\$8,399,000	\$0	\$0	\$0
Regular - ACA Optional 95/5%	\$8,399,000	\$7,979,000	\$0	\$0	\$420,000
Perinatal	\$488,000	\$0	\$317,000	\$171,000	\$0
Perinatal - ACA Optional 100%	\$27,000	\$27,000	\$0	\$0	\$0
Perinatal - ACA Optional 95/5%	\$27,000	\$25,000	\$0	\$0	\$1,000
Total	\$175,526,000	\$95,113,000	\$1,095,000	\$78,896,000	\$421,000

Funding:

100% Title XIX FF (4260-101-0890)

100% Title XXI FF (4260-113-0890)

100% ACA Title XIX FF (4260-101-0890)

95% ACA Title XIX FF / 5% GF (4260-101-0890/0001)

*Totals may differ due to rounding

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 64
IMPLEMENTATION DATE: 7/2012
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1726

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	\$32,632,000	\$29,194,000
- STATE FUNDS	\$12,293,000	\$12,643,900
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$32,632,000	\$29,194,000
STATE FUNDS	\$12,293,000	\$12,643,900
FEDERAL FUNDS	\$20,339,000	\$16,550,100

DESCRIPTION

Purpose:

This policy change estimates the reimbursement funds for the Drug Medi-Cal (DMC), Intensive Outpatient Treatment (IOT) services.

Authority:

Title 22, California Code of Regulations 51341.1 (b)(8); 51341.1 (d)(3), and 51516.1 (a)

Interdependent Policy Changes:

Not Applicable

Background:

IOT services are provided to beneficiaries with substance use disorder diagnoses. These outpatient counseling and rehabilitation services are provided at least three hours per day, three days per week. Services include:

- Intake,
- Admission physical examinations,
- Treatment planning,
- Individual and group counseling,
- Parenting education,
- Medication Services,
- Collateral services, and
- Crisis intervention.

The DMC program provides certain medically necessary substance use disorder treatment services. These services are provided by certified providers under contract with the counties or with the State. Funding for the services is 50% CF and 50% Title XIX Federal Funds (FF). Certain aid codes are eligible for Title XXI federal reimbursement at 65% and 88%. This service was limited to Early and Periodic Screening Diagnosis and Treatment (EPSDT), pregnant and postpartum women.

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 64

With the provisions of the Affordable Care Act (ACA) starting January 1, 2014, the expansion of Medicaid coverage to previously ineligible persons is referred to as the ACA optional expansion. In addition, the ACA requires enrollment simplification for several current coverage groups and imposes a penalty upon the uninsured and are considered part of the ACA mandatory expansion. The populations are described below:

ACA Population	Description	Funding
Expanded	Medi-Cal eligible and enrolled, but not receiving services: Non-EPSDT, non-pregnant/postpartum	50% GF/50% FF Title XIX; Certain aid codes 65% FF Title XXI
Mandatory	Medi-Cal eligible, but not enrolled in Medi-Cal	50% GF/50% FFP Title XIX Certain aid codes 65% and 88% FF Title XXI
Optional	Previously ineligible for Medi-Cal before ACA	100% FFP Title XIX (CY 2014-2016); 95% FFP Title XIX/5% GF (CY 2017)

Reason for Change from Prior Estimate:

The reasons for change are due to updated caseload, rates and units of service (UOS) for the regular, EPSDT and perinatal populations.

Methodology:

1. The DMC eligible clients are categorized into three groups: Regular, EPSDT, and Perinatal.
2. The caseload projections are based on complete caseload data from January 2010 through March 2015.
3. The UOS is based on the approved units divided by the caseload. Complete data from July 2013 through June 2014 was used to calculate the average UOS.
4. The proposed DMC rates are based on the developed rates or the FY 2009-10 Budget Act rates adjusted for the cumulative growth in the Implicit Price (CIP) Deflator for the Cost of Goods and Services to Governmental Agencies reported by the Department of Finance, whichever is lower. FY 2015-16 and FY 2016-17 budgeted amounts are based on the FY 2015-16 rates. For more information about the FY 2016-17 rates, see the Annual Rate Adjustment policy change.
5. The cost estimate is developed by the following: UOS x Rate x Caseload.

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 64

6. Amounts may differ due to rounding.

			FY 2015-16		FY 2016-17	
	UOS	Rates	Caseload	Total	Caseload	Total
Current						
Regular	18.7	\$58.30	1,964	\$2,142,000	1,839	\$2,005,000
EPSDT	38.5	\$58.30	832	\$1,867,000	779	\$1,748,000
Perinatal	32.9	\$82.10	214	\$578,000	200	\$541,000
Subtotal			3,010	\$4,587,000	2,818	\$4,294,000
Expanded						
Regular	18.7	\$58.30	22,578	\$24,615,000	22,582	\$24,619,000
EPSDT	38.5	\$58.30	-	\$0	-	\$0
Perinatal	32.9	\$82.10	-	\$0	-	\$0
Subtotal			22,578	\$24,615,000	22,582	\$24,619,000
Mandatory						
Regular	18.7	\$58.30	17	\$19,000	22	\$24,000
EPSDT	38.5	\$58.30	238	\$533,000	302	\$678,000
Perinatal	32.9	\$82.10	25	\$69,000	32	\$87,000
Subtotal			280	\$621,000	356	\$789,000
Optional						
Regular	18.7	\$58.30	305	\$333,000	357	\$389,000
EPSDT	38.5	\$58.30	-	\$0	-	\$0
Perinatal	32.9	\$82.10	388	\$1,049,000	453	\$1,225,000
Subtotal			694	\$1,382,000	810	\$1,614,000
Total				\$31,205,000		\$31,316,000

INTENSIVE OUTPATIENT TREATMENT SERVICES**BASE POLICY CHANGE NUMBER: 64**

7. Based on historical claims received, assume 75% of each fiscal year claims will be paid in the year the services occurred. The remaining 25% will be paid in the following year.

Fiscal Year	Accrual	FY 2015-16	FY 2016-17
Regular	\$34,821,000	\$8,705,250	\$0
Perinatal	\$8,922,000	\$2,230,500	\$0
FY 2014-15	\$43,743,000	\$10,935,750	\$0
Regular	\$29,509,000	\$22,131,750	\$7,377,250
Perinatal	\$1,696,000	\$1,272,000	\$424,000
FY 2015-16	\$31,205,000	\$23,403,750	\$7,801,250
Regular	\$29,463,000	\$0	\$22,097,250
Perinatal	\$1,853,000	\$0	\$1,389,750
FY 2016-17	\$31,316,000	\$0	\$23,487,000
Total		\$34,339,500	\$31,288,250

8. Funding for current beneficiaries is 50% CF and 50% FF. Beneficiaries in the expanded and mandatory categories are funded 50% GF and 50% FF. Minor consent costs are funded 100% by the counties. Beneficiaries in the optional category are funded 100% FF (95% FF and 5% GF starting January 2017). A portion of children are funded 65% FF and 35% GF (88% FF and 12% GF starting October 2015) and the remaining children population at 50% FF and 50% GF.

FY 2015-16	TF	FF Title XIX	FF Title XXI	CF	GF
Current					
Regular	\$4,963,000	\$914,000	\$2,580,000	\$1,469,000	\$0
Perinatal	\$682,000	\$5,000	\$438,000	\$239,000	\$0
Expanded					
Regular	\$24,141,000	\$11,986,000	\$139,000	\$0	\$12,016,000
Perinatal	\$0	\$0	\$0	\$0	\$0
Mandatory					
Regular	\$1,193,000	\$19,000	\$950,000	\$0	\$224,000
Perinatal	\$151,000	\$1,000	\$97,000	\$0	\$53,000
Optional					
Regular	\$1,902,000	\$1,902,000	\$0	\$0	\$0
Perinatal	\$1,308,000	\$1,308,000	\$0	\$0	\$0
Total	\$34,340,000	\$16,135,000	\$4,204,000	\$1,708,000	\$12,293,000

INTENSIVE OUTPATIENT TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 64

FY 2016-17	TF	FF Title XIX	FF Title XXI	CF	GF
Current					
Regular	\$3,815,000	\$1,901,000	\$13,000	\$1,901,000	\$0
Perinatal	\$551,000	\$4,000	\$354,000	\$193,000	\$0
Expanded					
Regular	\$24,618,000	\$12,222,000	\$152,000	\$0	\$12,244,000
Perinatal	\$0	\$0	\$0	\$0	\$0
Mandatory					
Regular	\$664,000	\$332,000	\$0	\$0	\$332,000
Perinatal	\$83,000	\$1,000	\$53,000	\$0	\$29,000
Optional					
Regular 100% FF	\$188,000	\$188,000	\$0	\$0	\$0
Regular 95% FF / 5% GF	\$187,000	\$178,000	\$0	\$0	\$9,000
Perinatal 100% FF	\$591,000	\$591,000	\$0	\$0	\$0
Perinatal 95% FF / 5% GF	\$591,000	\$561,000	\$0	\$0	\$30,000
Total	\$31,288,000	\$15,978,000	\$572,000	\$2,094,000	\$12,644,000

Funding:

100% General Fund (4260-101-0001)

100% Title XIX FF (4260-101-0890)

100% Title XXI FF (4260-113-0890)

100% ACA Title XIX FF (4260-101-0890)

95% ACA Title XIX FF / 5% GF (4260-101-0890/0001)

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 66
IMPLEMENTATION DATE: 7/2012
ANALYST: Joel Singh
FISCAL REFERENCE NUMBER: 1727

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	\$14,495,000	\$14,617,000
- STATE FUNDS	\$0	\$121,100
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$14,495,000	\$14,617,000
STATE FUNDS	\$0	\$121,100
FEDERAL FUNDS	\$14,495,000	\$14,495,900

DESCRIPTION

Purpose:

This policy change estimates the federal reimbursement funds for the Drug Medi-Cal (DMC), Outpatient Drug Free (ODF) counseling treatment service.

Authority:

Title 22, California Code of Regulations 51341.1 (b)(18); 51341.1 (d)(2); 51516.1 (a)

Interdependent Policy Changes:

Not Applicable

Background:

ODF counseling treatment services are designed to stabilize and rehabilitate Medi-Cal beneficiaries with substance use disorder diagnosis in an outpatient setting. This includes services under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Each ODF participant receives at least two group, face-to-face, counseling sessions per month. Counseling and rehabilitation services include:

- Admission physical examinations,
- Intake,
- Medical necessity establishment,
- Medication services,
- Treatment and discharge planning,
- Crisis intervention,
- Collateral services, and
- Individual and group counseling.

The DMC program provides certain medically necessary substance use disorder treatment services. These services are provided by certified providers under contract with the counties or with the State. Funding for the services is generally 50% CF and 50% Title XIX Federal Funds (FF). Certain aid codes are eligible for Title XXI federal reimbursement at 65% and 88%. ACA Optional population is eligible for Title XIX federal reimbursement at 100% until December 2016 and 95% beginning January 2017.

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 66

Reason for Change from Prior Estimate:

The change is due to updated caseload, rates, and units of service (UOS).

Methodology:

1. The DMC eligible clients are categorized into four groups: Regular, EPSDT, Minor Consent (MC), and Perinatal.
2. The caseload projections are based on complete caseload data from January 2010 through March 2015.
3. The Units of Service (UOS) data is based on the most recent complete data, July 2013-June 2014, to calculate an average UOS.
4. Separate DMC reimbursement rates apply for perinatal and non-perinatal patients.
5. The proposed DMC rates are based on the developed rates or the FY 2009-10 Budget Act rates adjusted for the cumulative Implicit Price (CIP) Deflator for the Cost of Goods and Services to Governmental Agencies reported by the Department of Finance (DOF), whichever is lower. FY 2015-16 and FY 2016-17 budgeted amounts are based on the FY 2015-16 required rates. For more information about the FY 2016-17 rates, see the Annual Rate Adjustment policy change.
6. The cost estimate is developed by the following: UOS x Rate x Caseload.
7. Amounts may contain rounding differences.

	UOS	Rates	FY 2015-16		FY 2016-17	
			Caseload	Total	Caseload	Total
Current Population						
Regular						
Individual	2.9	\$66.93	19,402	\$3,766,000	16,774	\$3,256,000
Group	23	\$27.14	19,402	\$12,111,000	16,774	\$10,471,000
Subtotal				\$15,877,000		\$13,727,000
EPSDT						
Individual	4.8	\$66.93	4,153	\$1,334,000	3,591	\$1,154,000
Group	24.1	\$27.14	4,153	\$2,717,000	3,591	\$2,349,000
Subtotal				\$4,051,000		\$3,503,000
Minor Consent						
Individual	4.8	\$66.93	1,108	\$356,000	958	\$308,000
Group	21.1	\$27.14	1,108	\$635,000	958	\$549,000
Subtotal				\$991,000		\$857,000
Perinatal						
Individual	2.2	\$107.04	259	\$61,000	224	\$53,000
Group	13.8	\$52.11	259	\$186,000	224	\$161,000
Subtotal				\$247,000	-	\$214,000
Mandatory						
Regular						
Individual	2.9	\$66.93	585	\$113,000	1,184	\$230,000
Group	23	\$27.14	585	\$365,000	1,184	\$739,000
Subtotal				\$478,000		\$969,000

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 66

			FY 2015-16		FY 2016-17	
EPSDT						
Individual	4.8	\$66.93	219	\$70,000	444	\$143,000
Group	24.1	\$27.14	219	\$143,000	444	\$290,000
Subtotal				\$213,000		\$433,000
Minor Consent						
Individual	4.8	\$66.93	101	\$32,000	205	\$66,000
Group	21.1	\$27.14	101	\$58,000	205	\$117,000
Subtotal				\$90,000		\$183,000
Perinatal						
Individual	2.2	\$107.04	12	\$3,000	25	\$6,000
Group	13.8	\$52.11	12	\$9,000	25	\$18,000
Subtotal				\$12,000		\$24,000
Optional						
Regular						
Individual	2.9	\$66.93	3,997	\$776,000	6,387	\$1,240,000
Group	23	\$27.14	3,997	\$2,495,000	6,387	\$3,987,000
Subtotal				\$3,271,000		\$5,227,000
EPSDT						
Individual	4.8	\$66.93	-	\$0	-	\$0
Group	24.1	\$27.14	-	\$0	-	\$0
Subtotal				\$0		\$0
Perinatal						
Individual	2.2	\$107.04	75	\$18,000	121	\$28,000
Group	13.8	\$52.11	75	\$54,000	121	\$87,000
Subtotal				\$72,000		\$115,000
Total				\$25,302,000		\$ 25,252,000

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 66

8. Based on historical claims received, assume 75% of each fiscal year claims will be paid in the year the services occurred. The remaining 25% will be paid in the following year.

Fiscal Year	Accrual	FY 2015-16	FY 2016-17
Regular	\$32,083,000	\$7,938,250	\$0
Minor Consent	\$2,281,000	\$645,500	\$0
Perinatal	\$733,000	\$163,000	\$0
FY 2014-15	\$35,097,000	\$8,746,750	\$0
Current			
Regular	\$19,928,000	\$14,946,000	\$4,982,000
Minor Consent	\$991,000	\$743,250	\$247,750
Perinatal	\$247,000	\$185,250	\$61,750
Mandatory			
Regular	\$691,000	\$518,250	\$172,750
Minor Consent	\$90,000	\$67,500	\$22,500
Perinatal	\$12,000	\$9,000	\$3,000
Optional			
Regular	\$3,271,000	\$2,453,250	\$817,750
Perinatal	\$72,000	\$54,000	\$18,000
FY 2015-16	\$25,302,000	\$18,976,500	\$6,325,500
Current			
Regular	\$17,230,000	\$0	\$12,922,500
Minor Consent	\$857,000	\$0	\$642,750
Perinatal	\$214,000	\$0	\$160,500
Mandatory			
Regular	\$1,402,000	\$0	\$1,051,500
Minor Consent	\$183,000	\$0	\$137,250
Perinatal	\$24,000	\$0	\$18,000
Optional			
Regular	\$5,227,000	\$0	\$3,920,250
Perinatal	\$115,000	\$0	\$86,250
FY 2016-17	\$25,252,000	\$0	\$18,939,000
Total		\$27,723,250	\$25,264,500

OUTPATIENT DRUG FREE TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 66

9. Total estimated federal reimbursements for ODF treatment services are:

FY 2015-16	TF	FF	FF	GF	County
		(Title XIX)	(Title XXI)		
Current					
Regular	\$22,881,000	\$11,362,000	\$132,000	\$0	\$11,387,000
Minor Consent	\$1,389,000	\$0	\$0	\$0	\$1,389,000
Perinatal	\$348,000	\$2,000	\$224,000	\$0	\$122,000
Mandatory					
Regular	\$521,000	\$259,000	\$3,000	\$0	\$259,000
Minor Consent	\$68,000	\$0	\$0	\$0	\$68,000
Perinatal	\$9,000	\$0	\$6,000	\$0	\$3,000
Optional					
Regular	\$2,453,000	\$2,453,000	\$0	\$0	\$0
Perinatal	\$54,000	\$54,000	\$0	\$0	\$0
Total	\$27,723,000	\$14,130,000	\$365,000	\$0	\$13,228,000

FY 2016-17	TF	FF	FF	GF	County
		(Title XIX)	(Title XXI)		
Current					
Regular	\$17,903,000	\$8,890,000	\$110,000	\$0	\$8,903,000
Minor Consent	\$891,000	\$0	\$0	\$0	\$891,000
Perinatal	\$223,000	\$2,000	\$143,000	\$0	\$78,000
Mandatory					
Regular	\$1,225,000	\$608,000	\$8,000	\$0	\$609,000
Minor Consent	\$160,000	\$0	\$0	\$0	\$160,000
Perinatal	\$20,000	\$0	\$13,000	\$0	\$7,000
Optional					
Regular – 100% FF	\$2,369,000	\$2,369,000	\$0	\$0	\$0
Regular - 95% FF	\$2,369,000	\$2,251,000	\$0	\$118,000	\$0
Perinatal - 100% FF	\$52,000	\$52,000	\$0	\$0	\$0
Perinatal - 95% FF	\$53,000	\$50,000	\$0	\$3,000	\$0
Total	\$25,265,000	\$14,222,000	\$ 274,000	\$121,000	\$10,648,000

Funding:

100% Title XIX FF (4260-101-0890)

100% Title XXI FF (4260-113-0890)

100% ACA Title XIX FF (4260-101-0890)

95% ACA Title XIX FF / 5% GF (4260-101-0890/0001)

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 67
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Joel Singh
 FISCAL REFERENCE NUMBER: 1725

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$5,162,000	\$5,745,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$5,162,000	\$5,745,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$5,162,000	\$5,745,000

DESCRIPTION

Purpose:

This policy change estimates the reimbursement for the Drug Medi-Cal (DMC) Residential Treatment services.

Authority:

Title 22, California Code of Regulations 51341.1 (b)(20); 51341.1 (d)(4); 51516.1 (a)

Interdependent Policy Changes:

Not Applicable

Background:

The Residential Treatment Service (RTS) provides rehabilitation services to beneficiaries with substance use disorder diagnosis in a non-institutional, non-medical, residential setting. Each beneficiary lives on the premises and is supported in effort to restore, maintain, and apply interpersonal and independent living skills and access community support systems.

Supervision and treatment services are available day and night, seven days a week. The service provides a range of activities:

- Mother/Child habilitative and rehabilitative services,
- Service access (i.e. transportation to treatment),
- Education to reduce harmful effects of alcohol and drug on the mother and fetus or infant, and/or
- Coordination of ancillary services.

The DMC program provides certain medically necessary substance use treatment services. These services are provided by certified providers under contract with the counties or with the State. Perinatal services are reimbursed through the Medi-Cal program only when provided in a facility with a treatment capacity of 16 beds or less, not including beds occupied by children of residents. Room and board is not reimbursable through the Medi-Cal program.

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 67

RTS funding for both current and ACA mandatory expansion populations is 50% CF and 50% Title XIX Federal Funds (FF) with certain aid codes eligible for Title XXI federal reimbursement at 65%. Non-federal share of cost is budgeted by County Funds (CF).

Effective September 1, 2015, the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver was amended to allow the Department to expand DMC RTS coverage to non-perinatal beneficiaries in facilities with no bed capacity limit. Cost for the non-perinatal expansion population is budgeted in policy change titled Residential Treatment Services Expansion.

Reason for Change from Prior Estimate:

The reasons for change are due to updated caseload, rates and units of service (UOS) for the perinatal population. In addition, costs for the RTS expansion to non-perinatal population is now budgeted in policy change titled Residential Treatment Services Expansion.

Methodology:

1. The caseload projections are based on complete caseload data from January 2010 through March 2015.
2. The UOS is based on the most recent complete data, July 2013-June 2014 to calculate an average UOS for existing caseload.
3. The proposed DMC rates are based on the developed rates or the FY 2009-10 Budget Act rates adjusted for the cumulative growth in the Implicit Price (CIP) Deflator for the Cost of Goods and Services to Governmental Agencies reported by the Department of Finance, whichever is lower. FY 2015-16 and FY 2016-17 budgeted amounts are based on the FY 2015-16 rates. For more information about FY 2016-17 rates, see the Annual Rate Adjustment policy change.
4. The cost estimate is developed by the following: Caseload x UOS x Rates

	Caseload	UOS	Rates	Total*
FY 2015-16	1,661	61.5	\$101.05	\$10,320,000
FY 2016-17	1,891	61.5	\$101.05	\$11,753,000

5. Based on historical claims received, assume 75% of each fiscal year claims will be paid in the year the services occurred. The remaining 25% will be paid in the following year.

Fiscal Year	Accrual	FY 2015-16	FY 2016-17
FY 2014-15	\$10,038,000	\$2,510,000	\$0
FY 2015-16	\$10,320,000	\$7,740,000	\$2,580,000
FY 2016-17	\$11,753,000	\$0	\$8,815,000
Total		\$10,250,000	\$11,395,000

RESIDENTIAL TREATMENT SERVICES

BASE POLICY CHANGE NUMBER: 67

Funding:

FY 2015-16	TF	FFP	CF
100% Title XIX FFP (4260-101-0890)	\$10,137,000	\$5,069,000	\$5,068,000
100% Title XXI FFP (4260-113-0890)	\$113,000	\$93,000	\$20,000
Total	\$10,250,000	\$5,162,000	\$5,088,000

FY 2016-17	TF	FFP	CF
100% Title XIX FFP (4260-101-0890)	\$11,270,000	\$5,635,000	\$5,635,000
100% Title XXI FFP (4260-113-0890)	\$125,000	\$110,000	\$15,000
Total	\$11,395,000	\$5,745,000	\$5,650,000

*Totals may differ due to rounding

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER: 70
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1780

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	\$909,985,000	\$897,363,000
- STATE FUNDS	\$70,411,000	\$77,055,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$909,985,000	\$897,363,000
STATE FUNDS	\$70,411,000	\$77,055,800
FEDERAL FUNDS	\$839,574,000	\$820,307,200

DESCRIPTION

Purpose:

This policy change estimates the base cost for specialty mental health services (SMHS) provided to adults (21 years of age and older).

Authority

Welfare & Institutions Code 14680-14685.1
 Specialty Mental Health Consolidation Program Waiver

Interdependent Policy Changes:

Not Applicable

Background:

The Medi-Cal SMHS program is "carved-out" of the broader Medi-Cal program and is administered by the Department under the authority of a waiver approved by the Centers for Medicare and Medicaid Services (CMS). The Department contracts with a Mental Health Plan (MHP) in each county to provide or arrange for the provision of Medi-Cal SMHS. All MHPs are county mental health departments.

SMHS are Medi-Cal entitlement services for adults and children that meet medical necessity criteria, which consist of having a specific covered diagnosis, functional impairment, and meeting intervention criteria. MHPs must certify that they incurred a cost before seeking federal reimbursement through claims to the State. MHPs are responsible for the non-federal share of Medi-Cal SMHS. Mental health services for Medi-Cal beneficiaries who do not meet the criteria for SMHS are provided under the broader Medi-Cal program either through managed care (MC) plans or fee-for-service (FFS).

This policy change budgets the costs associated with SMHS for adults. A separate policy change budgets the costs associated with SMHS for children.

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER: 70

The following Medi-Cal SMHS are available for adults:

- Adult Residential Treatment Services
- Crisis Intervention
- Crisis Stabilization
- Crisis Residential Treatment Services
- Day Rehabilitation
- Day Treatment Intensive
- Medication Support Services
- Psychiatric Health Facility Services
- Psychiatric Inpatient Hospital Services
- Targeted Case Management
- Therapy and Other Service Activities

Reason for Change from Prior Estimate:

The approved claims data has been updated to include six months of additional data.

Methodology:

1. The costs and clients are developed using 70 months of SD/MC and 70 months of FFS/MC approved claims data, excluding disallowed claims. The SD/MC data is current as of June 30, 2015, with dates of service from June 2009 through March 2015. The FFS data is current as of June 30, 2015, with dates of service from April 2009 through January 2015.
2. Due to the lag in reporting of claims data, the six most recent months of data are weighted (Lag Weights) based on observed claiming trends to create projected final claims data.
3. Applying more weight to recent data necessitates the need to ensure that lag weight adjusted claims data (a process by which months of partial data reporting is extrapolated to create estimates of final monthly claims) is as complete and accurate as possible. The development and application of lag weights is based upon historical reporting trends of the counties.
4. The forecast is based on a service year of costs. This accrual cost is below:

(Dollars In Thousands)

	Total	SD/MC	FFS Inpatient
FY 2013-14	\$1,124,291	\$990,165	\$134,126
FY 2014-15	\$1,181,903	\$1,044,001	\$137,902
FY 2015-16	\$1,240,248	\$1,098,174	\$142,074
FY 2016-17	\$1,298,592	\$1,152,347	\$146,245

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER: 70

5. On a cash basis for FY 2015-16, the Department will be paying 1% of FY 2013-14 claims, 21% of FY 2014-15 claims, and 78% of FY 2015-16 claims for SD/MC claims. For FFS Inpatient adult's claims, the Department will be paying 1% of FY 2013-14 claims, 28% of FY 2013-14 claims, and 71% of FY 2015-16 claims. Amounts may contain rounding differences. The cash amounts for Adult SMHS are:

(Dollars In Thousands)

	Total	SD/MC	FFS Inpatient
FY 2013-14	\$11,243	\$9,902	\$1,341
FY 2014-15	\$258,089	\$219,336	\$38,753
FY 2015-16	\$957,203	\$856,475	\$100,728
Total FY 2015-16	\$1,226,535	\$1,085,713	\$140,822

6. On a cash basis for FY 2016-17, the Department will be paying 1% of FY 2014-15 claims, 21% of FY 2015-16 claims, and 78% of FY 2016-17 claims for SD/MC claims. For FFS Inpatient adult's claims, the Department will be paying 1% of FY 2014-15 claims, 28% of FY 2015-16 claims, and 71% of FY 2016-17 claims. Amounts may contain rounding differences. The cash amounts for Adult SMHS are:

(Dollars In Thousands)

	Total	SD/MC	FFS Inpatient
FY 2014-15	\$11,819	\$10,440	\$1,379
FY 2015-16	\$270,642	\$230,717	\$39,925
FY 2016-17	\$1,002,412	\$898,727	\$103,685
Total FY 2016-17	\$1,284,873	\$1,139,884	\$144,989

7. Medi-Cal (MC) claims are eligible for 50% federal reimbursement. General Fund (GF) reimbursement authority is needed to account for the timing of the reimbursement from the county realignment funds to the Department.

(Dollars In Thousands)

Cash Estimate	TF	FF	County	GF Reimbursement
Total FY 2015-16	\$1,226,535	\$613,268	\$542,856	\$70,411
Total FY 2016-17	\$1,284,873	\$642,437	\$569,941	\$72,495

8. Assume ACA impact to SMHS for Adults is \$226,306,000 in FY 2015-16, funded by 100% federal funds (FF), and \$182,431,000 in FY 2016-17 funded by 95% FF and 5% GF beginning January 1, 2017.

(Dollars in Thousands)

Cash Estimate	TF	FF	County	GF	GF Reimbursement
Total FY 2015-16	\$1,452,841	\$839,574	\$542,856	\$0	\$70,411
Total FY 2016-17	\$1,467,304	\$820,307	\$569,941	\$4,561	\$72,495

SMHS FOR ADULTS

BASE POLICY CHANGE NUMBER: 70

9. This table shows the forecast of Medi-Cal beneficiaries who will receive SD/MC SMHS and FFS/MC psychiatric inpatient hospital services in FY 2015-16 and FY 2016-17.

	FY 2015-16 Utilization	FY 2016-17 Utilization
SD/MC	378,558	403,059
FFS	27,749	29,851
TOTAL	406,307	432,910

Funding:

100% Title XIX FFP (4260-101-0890)
100% Reimbursement (4260-601-0995)
100% Title XIX ACA FFP (4260-101-0890)
95% Title XIX FF / 5% GF (4260-101-0001/0890)

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 71
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1779

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	\$1,016,690,000	\$1,090,478,000
- STATE FUNDS	\$41,899,000	\$44,167,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,016,690,000	\$1,090,478,000
STATE FUNDS	\$41,899,000	\$44,167,000
FEDERAL FUNDS	\$974,791,000	\$1,046,311,000

DESCRIPTION

Purpose:

This policy change estimates the base cost for specialty mental health services (SMHS) provided to children (birth through 20 years of age).

Authority:

Welfare & Institutions Code 14680-14685.1
 Specialty Mental Health Consolidation Program Waiver

Interdependent Policy Changes:

Not Applicable

Background:

The Medi-Cal SMHS program is "carved-out" of the broader Medi-Cal program and is administered by the Department under the authority of a waiver approved by the Centers for Medicare and Medicaid Services (CMS). The Department contracts with a Mental Health Plan (MHP) in each county to provide or arrange for the provision of Medi-Cal SMHS. All MHPs are county mental health departments.

SMHS are Medi-Cal entitlement services for adults and children that meet medical necessity criteria, which consist of having a specific covered diagnosis, functional impairment, and meeting intervention criteria. MHPs must certify that they incurred a cost before seeking federal reimbursement through claims to the State. MHPs are responsible for the non-federal share of Medi-Cal SMHS. Mental health services for Medi-Cal beneficiaries who do not meet the criteria for SMHS are provided under the broader Medi-Cal program either through Medi-Cal managed care (MC) plans or the fee-for-service Medi-Cal (FFS/MC) program for beneficiaries not enrolled in a MC plan.

Children's SMHS are provided under the federal requirements of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit, which is available to full-scope beneficiaries under age 21. The EPSDT benefit is designed to meet the special physical, emotional, and developmental needs of low income children. This policy change budgets the costs associated with SMHS for children. A separate policy change budgets the costs associated with SMHS for adults.

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 71

The following Medi-Cal SMHS are available for children:

- Adult Residential Treatment Services*
- Crisis Intervention
- Crisis Stabilization
- Crisis Residential Treatment Services*
- Day Rehabilitation
- Day Treatment Intensive
- Medication Support Services
- Psychiatric Health Facility Services
- Psychiatric Inpatient Hospital Services
- Targeted Case Management
- Therapeutic Behavioral Services
- Therapy and Other Service Activities

*Children - Age 18 through 20

Reason for Change from Prior Estimate:

Expenditures increased due to the inclusion of additional approved claims data as of June 30, 2015. Also, there are enhanced federal funds of 88% beginning October 1, 2015, for CHIP expenditures.

Methodology:

1. The costs are developed using 70 months of Short-Doyle/Medi-Cal (SD/MC) and 70 months Fee-For-Service Medi-Cal (FFS/MC) approved claims data, excluding disallowed claims. The SD/MC data is current as of June 30, 2015, with dates of service from June 2009 through March 2015. The FFS data is current as of June 30, 2015, with dates of service from April 2009 through January 2015.
2. Applying more weight to recent data necessitates the need to ensure that lag weight adjusted claims data (a process by which months of partial data reporting is extrapolated to create estimates of final monthly claims) is as complete and accurate as possible. Therefore, the most recent six months of data are weighted (Lag Weights) based on observed claiming trends to create projected final claims and client data. The development and application of lag weights is based upon historical reporting trends of the counties.
3. This table displays the forecast of Medi-Cal beneficiaries who will receive SD/MC SMHS and FFS/MC psychiatric inpatient hospital services.

	FY 2015-16 Utilization	FY 2016-17 Utilization
SD/MC	280,569	292,284
FFS	14,040	14,944
TOTAL	294,609	307,228

SMHS FOR CHILDREN

BASE POLICY CHANGE NUMBER: 71

4. The forecast is based on a service year of costs. This accrual cost is below:

(Dollars In Thousands)

	TF	SD/MC	FFS Inpatient
FY 2013-14	\$1,671,870	\$1,596,255	\$75,615
FY 2014-15	\$1,749,995	\$1,665,538	\$84,457
FY 2015-16	\$1,849,625	\$1,759,003	\$90,622
FY 2016-17	\$1,949,254	\$1,852,467	\$96,787

5. On a cash basis for FY 2015-16, the Department will be paying 1% of FY 2013-14 claims, 21% of FY 2014-15 claims, and 78% of FY 2015-16 claims for SD/MC claims. For FFS Inpatient children's claims, the Department will be paying 1% of FY 2013-14 claims, 28% of FY 2014-15 claims, and 71% of FY 2015-16 claims. Amounts may contain rounding differences. The cash amounts for Children's SMHS are:

(Dollars In Thousands)

	TF	SD/MC	FFS Inpatient
FY 2013-14	\$16,719	\$15,963	\$756
FY 2014-15	\$373,649	\$349,915	\$23,734
FY 2015-16	\$1,436,111	\$1,371,861	\$64,250
Total FY 2015-16	\$1,826,479	\$1,737,739	\$88,740

6. On a cash basis for FY 2016-17, the Department will be paying 1% of FY 2014-15 claims, 21% of FY 2015-16 claims, and 78% of FY 2016-17 claims for SD/MC claims. For FFS Inpatient children's claims, the Department will be paying 1% of FY 2014-15 claims, 28% of FY 2015-16 claims, and 71% of FY 2016-17 claims. Amounts may contain rounding differences. The cash amounts for Children's SMHS are:

(Dollars In Thousands)

	TF	SD/MC	FFS Inpatient
FY 2014-15	\$17,500	\$16,655	\$845
FY 2015-16	\$395,017	\$369,551	\$25,466
FY 2016-17	\$1,513,377	\$1,444,756	\$68,621
Total FY 2016-17	\$1,925,894	\$1,830,962	\$94,932

7. Medicaid Expansion Children's Health Insurance Program (M-CHIP) claims are eligible for federal reimbursement at 65% and 88% (beginning October 1, 2015). Medi-Cal claims are eligible for 50% federal reimbursement. GF reimbursement authority is needed to account for the timing of the reimbursement from the county realignment funds to the Department.

(Dollars In Thousands)

	TF	FF	M-CHIP*	County	GF Reimbursement
FY 2015-16	\$1,826,480	\$817,811	\$156,980	\$809,790	\$41,899
FY 2016-17	\$1,925,894	\$853,259	\$193,052	\$835,416	\$44,167

Funding:

100% Title XIX FFP (4260-101-0890)
 100% Title XXI FFP (4260-113-0890)*
 100% Reimbursement (4260-601-0995)

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 105
 IMPLEMENTATION DATE: 7/2000
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 56

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	\$20,052,924,000	\$18,469,452,000
- STATE FUNDS	\$5,223,164,970	\$5,559,784,560
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$20,052,924,000	\$18,469,452,000
STATE FUNDS	\$5,223,164,970	\$5,559,784,560
FEDERAL FUNDS	\$14,829,759,030	\$12,909,667,440

DESCRIPTION

Purpose:

This policy change estimates the managed care capitation costs for the Two-Plan model.

Authority:

Welfare & Institutions Code 14087.3

Interdependent Policy Changes:

PC 111 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 129 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 130 MCO Tax Managed Care Plans

Background:

Under the Two-Plan model, each designated county has two managed care plans, a local initiative and a commercial plan, which provide medically necessary services to Medi-Cal beneficiaries residing within the county. There are 14 counties in the Two Plan Model: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare.

Reason for Change from Prior Estimate:

ACA Optional Expansion eligibles are now included in the managed care PCs. FY 2014-15 rates are used for FY 2015-16 payments, and proposed FY 2015-16 rates are used for FY 2016-17. Lastly, the estimated Hepatitis C costs increased from the May Appropriation.

Methodology:

1. Capitation rates are rebased annually. Federal rules require that the rates be developed according to generally accepted actuarial principles and must be certified by an actuary as actuarially sound in order to ensure federal financial participation. The rates are implemented based on the rate year of the managed care model types. The rebasing process includes refreshed data and adjustments to trends.

TWO PLAN MODEL

BASE POLICY CHANGE NUMBER: 105

2. All rates are set by the Department at the lower bound of the rate range. For those plans participating in an intergovernmental transfer (IGT), the lower bound rates plus the total funds of the IGT increase cannot exceed the upper bound of the rate range. IGT increases are budgeted in PC 112 Managed Care Rate Range IGTs. The base IGT capitation payments for Alameda County are budgeted in this policy change.
3. Rates have been redetermined for FY 2015-16.
4. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of \$270,550,000 for FY 2015-16 and \$421,030,000 for FY 2016-17 were included in the rates.
5. The savings from AB 97 are included in the rates. Savings of \$120,343,000 for FY 2015-16 and \$158,543,000 for FY 2016-17 were included in the rates. Rates include the savings for application to primary care physicians effective January 1, 2015.
6. Services provided through the LA Mobile Vision Pilot Project are included in the rates. These were previously budgeted in PC 53 Pediatric Mobile Vision Project.
7. Capitation rate increases due to the MCO Tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from the tax fund on a quarterly basis. The reimbursement is budgeted in the MCO Tax Mgd. Care Plans - Funding Adjustment policy changes.
8. The Department receives federal reimbursement of 90% for family planning services.
9. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted at a FMAP split of 65/35 in the managed care model policy changes. Beginning October 1, 2015, a FMAP of 88/12 will be budgeted for OTLICP.

TWO PLAN MODEL
BASE POLICY CHANGE NUMBER: 105

(Dollars in Thousands)

FY 2015-16	Eligible Months	Total
Alameda	3,649,980	\$1,138,796
Contra Costa	2,295,486	\$666,338
Kern	3,447,579	\$768,389
Los Angeles	32,415,865	\$8,852,095
Riverside	7,496,627	\$1,821,627
San Bernardino	7,619,222	\$1,816,674
San Francisco	1,769,721	\$641,472
San Joaquin	2,801,979	\$649,019
Santa Clara	3,692,969	\$1,011,253
Stanislaus	2,179,213	\$631,833
Tulare	2,264,851	\$478,680
Fresno	4,424,466	\$1,100,435
Kings	522,411	\$122,651
Madera	634,169	\$148,500
Total	75,214,536	\$19,847,762
Hepatitis C Adjustment		\$205,162
Total FY 2015-16		\$20,052,924

(Dollars in Thousands)

Included in the Above Dollars	FY 2015-16
Mental Health	\$270,550
Blood Factor	(\$10,715)
AB 97	(\$120,343)

TWO PLAN MODEL
BASE POLICY CHANGE NUMBER: 105

(Dollars in Thousands)

FY 2016-17	Eligible Months	Total
Alameda	3,691,420	\$1,003,984
Contra Costa	2,320,352	\$624,606
Kern	3,459,345	\$770,050
Los Angeles	32,666,939	\$7,990,580
Riverside	7,595,694	\$1,703,458
San Bernardino	7,712,085	\$1,721,316
San Francisco	1,785,937	\$560,935
San Joaquin	2,819,528	\$624,569
Santa Clara	3,717,047	\$928,191
Stanislaus	2,190,703	\$598,066
Tulare	2,275,315	\$445,309
Fresno	4,462,434	\$1,054,741
Kings	524,688	\$108,422
Madera	636,524	\$139,704
Total	75,858,011	\$18,273,931
Heptatitis C Adjustment		\$195,521
Total FY 2016-17		\$18,469,452

(Dollars in Thousands)

Included in the Above Dollars	FY 2016-17
Mental Health	\$287,903
Blood Factor	(\$14,612)
AB 97	(\$158,543)

TWO PLAN MODEL
BASE POLICY CHANGE NUMBER: 105

Funding:

(Dollars in Thousands)

FY 2015-16	TF	GF	FF
Title XIX 50/50	\$10,118,704	\$5,059,352	\$5,059,352
State GF	\$32,227	\$32,227	\$0
ACA 100%FFP	\$9,108,189	\$0	\$9,108,189
Family Planning 90/10 GF	\$120,183	\$12,018	\$108,165
Title XXI 65/35 GF	\$168,405	\$58,942	\$109,463
Title XXI 88/12 GF	\$505,216	\$60,626	\$444,590
Total	\$20,052,924	\$5,223,165	\$14,829,759

FY 2016-17	TF	GF	FF
Title XIX 50/50	\$10,515,121	\$5,257,561	\$5,257,561
State GF	\$32,230	\$32,230	\$0
ACA 95/5 GF	\$3,569,760	\$178,488	\$3,391,272
ACA 100%FFP	\$3,569,760	\$0	\$3,569,760
Family Planning 90/10 GF	\$120,183	\$12,018	\$108,165
Title XXI 88/12 GF	\$662,398	\$79,488	\$582,910
Total	\$18,469,452	\$5,559,784	\$12,909,668

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 106
 IMPLEMENTATION DATE: 12/1987
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 57

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$8,353,031,000	\$7,458,135,000
- STATE FUNDS	\$2,156,030,440	\$2,155,363,960
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$8,353,031,000	\$7,458,135,000
STATE FUNDS	\$2,156,030,440	\$2,155,363,960
FEDERAL FUNDS	\$6,197,000,560	\$5,302,771,040

DESCRIPTION

Purpose:

This policy change estimates the managed care capitation costs for the County Organized Health Systems (COHS) model.

Authority:

Welfare & Institutions Code 14087.3

Interdependent Policy Changes:

PC 124 Managed Care Expansion to Rural Counties
 PC 111 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 129 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 130 MCO Tax Managed Care Plans

Background:

A COHS is a local agency created by a county board of supervisors to contract with the Medi-Cal program. There are 22 counties in the COHS Model: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, Santa Barbara, Santa Cruz, San Mateo, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura, and Yolo.

Reason for Change from Prior Estimate:

ACA Optional Expansion eligibles are now included in the managed care PCs. FY 2014-15 rates are used for FY 2015-16 payments, and proposed FY 2015-16 rates are used for FY 2016-17. Lastly, the estimated Hepatitis C costs increased from the May Appropriation.

Methodology:

1. Capitation rates are rebased annually. Federal rules require that the rates be developed according to generally accepted actuarial principles and must be certified by an actuary as actuarially sound in order to ensure federal financial participation. The rates are implemented based on the rate year of the managed care model types. The rebasing process includes refreshed data and adjustments to trends.

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 106

2. All rates are set by the Department at the lower bound of the rate range. For those plans participating in an intergovernmental transfer (IGT), the lower bound rates plus the total funds of the IGT increase cannot exceed the upper bound of the rate range. IGT increases are budgeted in PC 115 Managed Care Rate Range IGTs. The base IGT capitation payments for San Mateo County are budgeted in this policy change.
3. Currently, all COHS plans have assumed risk for long term care services. The Partnership Health Plan of California (PHC) includes undocumented residents and documented alien beneficiaries (OBRA).
4. Rates have been redetermined for FY 2015-16.
5. Capitation rate increases due to the MCO Tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from the tax fund on a quarterly basis. The reimbursement is budgeted in the MCO Tax Mgd. Care Plans - Funding Adjustment policy change.
6. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of \$71,332,000 for FY 2015-16 and \$91,328,000 for FY 2016-17 were included in the rates.
7. The savings from AB 97 are included in the rates. Savings of \$37,043,000 for FY 2015-16 and \$42,563,000 for FY 2016-17 were included in the rates. Rates include the savings for application to primary care providers effective January 1, 2015.
8. The Department receives federal reimbursement of 90% for family planning services.
9. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted at a FMAP split of 65/35 in the managed care model policy changes. Beginning October 1, 2015, a FMAP split of 88/12 will be budgeted for OTLICP.

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 106

(Dollars in Thousands)

FY 2015-16	Eligible Months	Total
501- San Luis Obispo	636,941	\$198,711
502- SantaBarbara	1,343,786	\$410,526
503- San Mateo	1,280,993	\$494,990
504- Solano	1,277,138	\$475,732
505- Santa Cruz	792,169	\$272,899
506- Orange	8,924,325	\$2,952,164
507- Napa	331,174	\$124,357
508- Monterey	1,732,456	\$534,128
509- Yolo	607,200	\$217,517
513- Sonoma	1,298,687	\$484,001
514- Merced	1,471,596	\$366,956
510 - Marin	425,135	\$194,196
512 - Mendocino	424,808	\$143,121
515 - Ventura	2,296,514	\$726,080
523 - Del Norte	129,942	\$40,822
517 - Humboldt	568,953	\$182,296
511 - Lake	333,886	\$103,644
518 - Lassen	82,794	\$26,273
519 - Modoc	35,097	\$12,319
520 - Shasta	731,787	\$242,258
521 - Siskiyou	191,714	\$63,421
522 - Trinity	54,858	\$18,014
Total FY 2015-16	24,971,954	\$8,284,425
Hepatitis C Adjustmt		\$68,606
Total with Adjustments		\$8,353,031

(Dollars in Thousands)

Included in Above Dollars	FY 2015-16
Mental Health	\$71,332
Blood Factor	(\$18,839)
AB 97	(\$37,043)

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 106

(Dollars in Thousands)

FY 2016-17	Eligible Months	Total
501- San Luis Obispo	641,967	\$190,183
502- SantaBarbara	1,351,011	\$404,041
503- San Mateo	1,287,419	\$408,641
504- Solano	1,284,972	\$415,497
505- Santa Cruz	793,545	\$232,654
506-Orange	8,971,661	\$2,498,801
507- Napa	335,466	\$122,387
508- Monterey	1,747,984	\$478,114
509- Yolo	610,457	\$198,523
513- Sonoma	1,311,536	\$439,186
514- Merced	1,480,598	\$356,810
510 - Marin	427,303	\$164,038
512 - Mendocino	425,783	\$130,121
515 -Ventura	2,302,405	\$637,687
523 - DelNorte	130,014	\$42,183
517 -Humboldt	570,853	\$191,242
511 -Lake	334,893	\$107,626
518 -Lassen	82,992	\$27,158
519 -Modoc	35,327	\$12,688
520 - Shasta	734,023	\$250,894
521 - Siskiyou	192,153	\$65,697
522 - Trinity	55,039	\$18,814
Total FY 2016-17	25,107,401	\$7,392,985
Hepatitis C Adjustment		\$65,150
Total with Adjustments		\$7,458,135

(Dollars in Thousands)

Included in Above Dollars	FY 2016-17
Mental Health	\$91,328
Blood Factor	(\$31,252)
AB 97	(\$42,563)

COUNTY ORGANIZED HEALTH SYSTEMS

BASE POLICY CHANGE NUMBER: 106

Funding:

(Dollars in Thousands)

FY 2015-16	TF	GF	FF
Title XIX 50/50	\$4,144,889	\$2,072,445	\$2,072,445
State GF	\$14,303	\$14,303	\$0
Family Planning 90/10 GF	\$42,596	\$4,260	\$38,336
Title XXI 65/35 GF	\$91,582	\$32,054	\$59,528
Title XXI 88/12 GF	\$274,747	\$32,970	\$241,777
ACA 100%FFP	\$3,784,914	\$0	\$3,784,914
Total	\$8,353,031	\$2,156,032	\$6,196,999

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
Title XIX 50/50	\$4,037,655	\$2,018,828	\$2,018,828
State GF	\$14,319	\$14,319	\$0
Family Planning 90/10 GF	\$42,596	\$4,260	\$38,336
Title XXI 88/12 GF	\$356,518	\$42,782	\$313,736
ACA 100%FFP	\$1,503,524	\$0	\$1,503,524
ACA 95/5 GF	\$1,503,524	\$75,177	\$1,428,347
Total	\$7,458,135	\$2,155,365	\$5,302,771

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 107
 IMPLEMENTATION DATE: 4/1994
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 58

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$3,441,331,000	\$3,408,128,000
- STATE FUNDS	\$902,831,260	\$968,565,760
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,441,331,000	\$3,408,128,000
STATE FUNDS	\$902,831,260	\$968,565,760
FEDERAL FUNDS	\$2,538,499,740	\$2,439,562,240

DESCRIPTION

Purpose:

This policy change estimates the managed care capitation costs for the Geographic Managed Care (GMC) model plans.

Authority:

Welfare & Institutions Code 14087.3

Interdependent Policy Changes:

PC 111 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 129 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 130 MCO Tax Managed Care Plans

Background:

There are two counties in the GMC model: Sacramento and San Diego. In both counties, the Department contracts with several commercial plans providing more choices for the beneficiaries.

Reason for Change from Prior Estimate:

ACA Optional Expansion eligibles are now included in the managed care PCs. FY 2014-15 rates are used for FY 2015-16 payments, and proposed FY 2015-16 rates are used for FY 2016-17. Lastly, the estimated Hepatitis C costs increased from the May Appropriation.

Methodology:

1. Capitation rates are rebased annually. Federal rules require that the rates be developed according to generally accepted actuarial principles and must be certified by an actuary as actuarially sound in order to ensure federal financial participation. The rates are implemented based on the rate year of the managed care model types. The rebasing process includes refreshed data and adjustments to trends.

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 107

2. All rates are set by the Department at the lower bound of the rate range. For those plans participating in an intergovernmental transfer (IGT), the lower bound rates plus the total funds of the IGT increase cannot exceed the upper bound of the rate range. IGT increases are budgeted in PC 112 Managed Care Rate Range IGTs.
3. Rates have been redetermined for FY 2015-16.
4. Capitation rate increases due to MCO Tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from the Gross Premium Tax fund on a quarterly basis. The reimbursement is budgeted in the MCO Tax Mgd. Care Plans - Funding Adjustment policy changes.
5. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of \$45,275,000 for FY 2015-16 and \$47,816,000 for FY 2016-17 were included in the rates.
6. The savings from AB 97 are included in the rates. Savings of \$22,939,000 for FY 2015-16 and \$29,463,000 for FY 2016-17 were included in the rates. Rates include the savings for application to primary care providers effective January 1, 2015.
7. The FY 2015-16 and FY 2016-17 family planning is budgeted at a FMAP split of 90/10 in the managed care model policy changes.
8. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted at a FMAP split of 65/35 in the managed care model policy changes. Beginning October 1, 2015, a FMAP split of 88/12 will be budgeted for OTLICP.

(Dollars in Thousands)

FY 2015-16	Eligible Months	Total
Sacramento	4,902,131	\$1,243,599
San Diego	7,564,490	\$2,164,576
Total	12,466,621	\$3,408,175
Hepatitis C Adjustment		\$33,156
Total FY 2015-16		\$3,441,331

(Dollars in Thousands)

Included in Dollars Above	FY 2015-16
Mental Health	\$45,275
Blood Factor	(\$1,953)
AB 97	(\$22,939)

GEOGRAPHIC MANAGED CARE

BASE POLICY CHANGE NUMBER: 107

(Dollars in Thousands)

FY 2016-17	Eligible Months	Total
Sacramento	4,918,161	\$1,202,157
San Diego	7,619,157	\$2,174,468
Total	12,537,318	\$3,376,625
Hepatitis C Adjustment		\$31,503
Total FY 2016-17		\$3,408,128

(Dollars in Thousands)

Included in Dollars Above	FY 2016-17
Mental Health	\$47,816
Blood Factor	(\$4,648)
AB 97	(\$29,463)

Funding:

(Dollars in Thousands)

FY 2015-16	TF	GF	FF
Title XIX 50/50	\$1,737,667	\$868,833	\$868,833
State GF	\$5,544	\$5,544	\$0
Family Planning 90/10 GF	\$21,737	\$2,174	\$19,563
Title XXI 65/35 GF	\$37,014	\$12,955	\$24,059
Title XXI 88/12 GF	\$111,043	\$13,325	\$97,718
ACA Optional Expansion 100% FF	\$1,528,326	\$0	\$1,528,326
Total	\$3,441,331	\$902,831	\$2,538,500

(Dollars in Thousands)

FY 2016-17	TF	GF	FF
Title XIX 50/50	\$1,814,940	\$907,470	\$907,470
State GF	\$5,546	\$5,546	\$0
Family Planning 90/10 GF	\$21,737	\$2,174	\$19,563
Title XXI 88/12 GF	\$149,778	\$17,973	\$131,805
ACA Optional Expansion 100% FF	\$708,064	\$0	\$708,064
ACA Optional Expansion 95/5 GF	\$708,064	\$35,403	\$672,661
Total	\$3,408,128	\$968,566	\$2,439,563

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 110
 IMPLEMENTATION DATE: 11/2013
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1842

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	\$1,309,989,000	\$1,231,722,000
- STATE FUNDS	\$340,359,440	\$353,524,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,309,989,000	\$1,231,722,000
STATE FUNDS	\$340,359,440	\$353,524,800
FEDERAL FUNDS	\$969,629,560	\$878,197,200

DESCRIPTION

Purpose:

This policy change estimates the managed care capitation costs for the Regional model plans.

Authority:

AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:

PC 111 MCO Tax Mgd. Care Plans Incr. Cap. Rates
 PC 129 MCO Tax Mgd. Care Plans Funding Adjustment
 PC 130 MCO Tax Managed Care Plans

Background:

Managed care was previously in 30 counties. AB 1467 expanded managed care into the remaining 28 counties across the state. Expanding managed care into rural counties ensures that beneficiaries throughout the state receive health care through an organized delivery system that coordinated their care and leads to better health outcomes and lower costs.

There are 20 counties in the regional model: Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Imperial, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, Tuolumne, and Yuba.

Reason for Change from Prior Estimate:

ACA Optional Expansion eligibles are now included in the managed care PCs. FY 2014-15 rates are used for FY 2015-16 payments, and proposed FY 2015-16 rates are used for FY 2016-17.

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 110

Methodology:

1. Capitation rates are rebased annually. Federal rules require that the rates be developed according to generally accepted actuarial principles and must be certified by an actuary as actuarially sound in order to ensure federal financial participation. The rebasing process includes refreshed data and adjustments to trends.
2. Capitation rate increases due to MCO Tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from the Gross Premium Tax fund on a quarterly basis. The reimbursement is budgeted in the MCO Tax Mgd. Care Plans - Funding Adjustment policy changes.
3. All rates are set by the Department at the lower bound of the rate range. For those plans participating in an intergovernmental transfer (IGT), the lower bound rates plus the total funds of the IGT increase cannot exceed the upper bound of the rate range. IGT increases are budgeted in PC 112 Managed Care Rate Range IGTs.
4. Rates have been redetermined for FY 2015-16.
5. Services provided through the shift of non-specialty mental health into managed care are included in the rates. Costs of \$15,219,000 for FY 2015-16 and \$17,134,000 for FY 2016-17 were included in the rates.
6. The savings from AB 97 are included in the rates. Savings of \$3,981,000 for FY 2015-16 and \$5,228,000 for FY 2016-17 were included in the rates. Rates include the savings for application to the primary care providers effective January 1, 2015.
7. The FY 2015-16 and FY 2016-17 family planning is budgeted at a FMAP split of 90/10 in the managed care model policy changes.
8. Costs for the Optional Targeted Low Income Children Program (OTLICP) are budgeted at a FMAP split of 65/35 in the managed care model policy changes. Beginning October 1, 2015, a FMAP split of 88/12 will be budgeted for OTLICP.
9. Effective December 1, 2014, all non-dual Seniors and Persons with Disabilities (SPDs) were required to enroll.

REGIONAL MODEL
BASE POLICY CHANGE NUMBER: 110

(Dollars in Thousands)

FY 2015-16	Eligible Months	Total
Alpine	2,889	\$1,024
Amador	73,380	\$23,012
Butte	776,095	\$259,906
Calaveras	110,548	\$34,919
Colusa	76,441	\$17,511
El Dorado	338,178	\$107,350
Glenn	108,079	\$29,578
Inyo	46,473	\$13,262
Mariposa	44,309	\$13,779
Mono	29,959	\$8,183
Nevada	217,451	\$67,684
Placer	525,893	\$156,312
Plumas	50,844	\$17,317
Sierra	6,778	\$2,285
Sutter	370,694	\$102,011
Tehama	243,026	\$73,993
Tuolumne	133,394	\$43,385
Yuba	284,709	\$85,914
Imperial	638,559	\$218,500
San Benito	69,165	\$22,106
Total FY 2015-16	4,146,863	\$1,298,031
Hepatitis C Adjustment		\$11,958
Total with Adjustments		\$1,309,989

(Dollars in Thousands)

Included in Dollars Above	FY 2015-16
Mental Health	\$15,219
Blood Factor	(\$3,828)
AB 97	(\$3,981)

REGIONAL MODEL

BASE POLICY CHANGE NUMBER: 110

(Dollars in Thousands)

FY 2016-17	Eligible Months	Total
Alpine	2,884	\$936
Amador	73,361	\$21,355
Butte	776,789	\$247,318
Calaveras	110,527	\$32,539
Colusa	76,372	\$16,323
El Dorado	338,448	\$100,071
Glenn	107,976	\$27,932
Inyo	46,453	\$12,351
Mariposa	44,319	\$12,753
Mono	29,932	\$7,426
Nevada	217,343	\$62,861
Placer	526,087	\$145,404
Plumas	50,804	\$16,268
Sierra	6,777	\$2,110
Sutter	370,570	\$95,778
Tehama	243,144	\$70,791
Tuolumne	133,380	\$40,744
Yuba	284,730	\$82,031
Imperial	639,169	\$206,163
San Benito	70,335	\$19,270
Total FY 2016-17	4,149,401	\$1,220,424
Hepatitis C Adjustment		\$11,298
Total with Adjustments		\$1,231,722

(Dollars in Thousands)

Included in Dollars Above	FY 2016-17
Mental Health	\$17,134
Blood Factor	(\$5,796)
AB 97	(\$5,228)

Funding:

(Dollars in Thousands)

FY 2015-16		TF	GF	FF
Title XIX 50/50 FFP	4260-101-0001/0890	\$653,309	\$326,654	\$326,654
State GF	4260-101-0001	\$3,886	\$3,886	\$0
ACA 100% FFP	4260-101-0890	\$593,673	\$0	\$593,673
Family Planning 90/10 GF	4260-101-0001/0890	\$8,706	\$871	\$7,835
Title XXI FF 65/35 GF	4260-113-0001/0890	\$12,604	\$4,411	\$8,193
Title XXI FF 88/12 GF	4260-113-0001/0890	\$37,812	\$4,537	\$33,275
Total		\$1,309,990	\$340,359	\$969,631

REGIONAL MODEL
BASE POLICY CHANGE NUMBER: 110

(Dollars in Thousands)

FY 2016-17		TF	GF	FF
Title XIX 50/50 FFP	4260-101-0001/0890	\$660,574	\$330,287	\$330,287
State GF	4260-101-0001	\$3,888	\$3,888	\$0
ACA 95/5 GF	4260-101-0890	\$255,512	\$12,776	\$242,736
ACA 100% FFP	4260-101-0890	\$255,512	\$0	\$255,512
Family Planning 90/10 GF	4260-101-0001/0890	\$8,706	\$871	\$7,835
Title XXI FF 88/12 GF	4260-113-0001/0890	\$47,530	\$5,704	\$41,826
Total		\$1,231,722	\$353,526	\$878,196

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 114
 IMPLEMENTATION DATE: 7/1992
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 62

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$294,166,000	\$322,812,000
- STATE FUNDS	\$147,083,000	\$161,406,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$294,166,000	\$322,812,000
STATE FUNDS	\$147,083,000	\$161,406,000
FEDERAL FUNDS	\$147,083,000	\$161,406,000

DESCRIPTION

Purpose:

This policy change estimates the capitation payments under the Program of All-Inclusive Care for the Elderly (PACE).

Authority:

Welfare & Institutions Code 14591-14593
 Balanced Budget Act of 1997 (BBA)
 SB 870 (Chapter 40, Statutes 2014)

Interdependent Policy Changes:

Not Applicable

Background:

The PACE program is a capitated benefit that provides a comprehensive medical/social delivery system. Services are provided in a PACE center to older adults who would otherwise reside in nursing facilities. To be eligible, a person must be 55 years or older, reside in a PACE service area, be determined eligible at the nursing home level of care by the Department, and be able to live safely in their home or community at the time of enrollment. PACE providers assume full financial risk for participants' care without limits on amount, duration, or scope of services.

The Department currently has eleven contracts with PACE organizations for risk-based capitated life-time care for the frail elderly. The Department is finalizing an application for a new PACE organization and is expected to begin operations in April 2017. PACE rates are based upon Medi-Cal fee-for-service (FFS) expenditures for comparable populations and by law must be set at no less than 90% of the FFS Upper Payment Limits (UPL), pursuant to SB 870. PACE rates are set on a calendar year basis to coincide with the time period of the contracts.

PACE (Other M/C)
BASE POLICY CHANGE NUMBER: 114

Below is a list of PACE organizations:

PACE Organization	County	Operational
On Lok Lifeways	San Francisco	November 1, 1983
	Alameda	July 1, 2002
	Santa Clara	January 1, 2009
Centers for Elders' Independence	Alameda	June 1, 1992
	Contra Costa	June 1, 1992
Sutter Senior Care	Sacramento	August 1, 1992
AltaMed Senior BuenaCare	Los Angeles	January 1, 1996
St. Paul's PACE	San Diego	February 1, 2008
Los Angeles Jewish Home	Los Angeles	February 1, 2013
CalOptima PACE	Orange	September 1, 2013
InnovAge	San Bernardino	April 1, 2014
	Riverside	April 1, 2014
Central Valley Medical Svs.	Fresno	August 1, 2014
Redwood Coast	Humboldt	September 1, 2014
San Ysidro	San Diego	April 1, 2015
Hope Through Housing	San Bernardino	April 1, 2017
	Riverside	April 1, 2017

Reason for Change from Prior Estimate:

Estimated enrollment projections decreased by 2% in FY 2015-16 and increased 13% in FY 2016-17. A delay in implementation of 2015 PACE rates for all plans and 2014 rates for three plans increased costs for FY 2015-16.

Methodology:

1. Assume the 2014 and 2015 rates are calculated using the UPL for each year. The 2016 and 2017 rates will be calculated using the existing comparable population FFS UPL methodology.
2. FY 2015-16 and FY 2016-17 estimated funding is based on approved calendar year (CY) 2015 rates and projected CY 2016 rates and CY 2017 rates.
3. Assume enrollment will increase based on past enrollment to PACE organization by county and plan and impact of the CCI demonstration as experienced to date.
4. The Department is working with PACE organizations and proposing changes to current law to transition from a UPL-based methodology to an actuarially sound experienced-based methodology. The Department anticipates restructuring the methodology to determine the rates effective January 2017.
5. The Department is still processing three contract amendments to implement 2014 PACE rates for three PACE organizations currently paid at 2013 PACE rates. The Department anticipates receiving CMS approval and implementation of these contract amendments in September 2015. This will result in repayments of approximately \$113,000 and is expected to occur in FY 2015-16.
6. The Department will also recoup approximately \$169,000 due to a required shift to rates set at

PACE (Other M/C)

BASE POLICY CHANGE NUMBER: 114

95% of the UPL to rates set at 90% of the UPL for two of the PACE organizations that finished their first year of enrollment operations during 2014. This recoupment is expected to occur in FY 2015-16.

7. The Department anticipates receiving CMS approval of contract amendments implementing 2015 rates in October 2015, retroactive to January 2015. This results in a repayment of \$17,800,000 for the increase of Medi-Cal Only and Dual rates that were paid at 2014 PACE rates from January to June 2015. The repayment is expected to occur in FY 2015-16.

FY 2015-16	TF Cost (Rounded)	Eligible Months	Avg. Monthly Enrollment
Centers for Elders' Independence (Alameda and Contra Costa)	\$37,505,000	7,799	650
Sutter SeniorCare	\$12,761,000	2,967	247
AltaMed Senior BuenaCare	\$87,069,000	20,970	1,747
OnLok (SF, Alameda and Santa Clara)	\$81,482,000	16,419	1,368
St. Paul's PACE	\$26,140,000	6,063	505
Los Angeles Jewish Homes	\$6,716,000	1,650	137
CalOptima PACE	\$3,813,000	990	83
InnovAge (San Bernardino and Riverside)	\$11,199,000	2,710	226
Redwood Coast	\$3,003,000	897	75
Central Valley Medical Services	\$10,357,000	2,136	178
San Ysidro San Diego	\$3,497,000	827	69
Total Capitation Payments	\$283,542,000	63,428	5,285
2014 Rate Repayment	\$113,000		
2014 Rate Recoupment	(\$169,000)		
2015 Rate Repayment	\$10,680,000		
Total FY 2015-16	\$294,166,000		

*Totals may differ due to rounding.

PACE (Other M/C)
BASE POLICY CHANGE NUMBER: 114

FY 2016-17	TF Cost (Rounded)	Eligible Months	Avg. Monthly Enrollment
Centers for Elders' Independence (Alameda and Contra Costa)	\$39,942,000	8,140	678
Sutter SeniorCare	\$12,939,000	2,967	247
AltaMed Senior BuenaCare	\$93,232,000	22,053	1,838
OnLok (SF, Alameda and Santa Clara)	\$87,001,000	17,232	1,436
St. Paul's PACE	\$30,863,000	7,024	585
Los Angeles Jewish Homes	\$8,588,000	2,070	172
CalOptima PACE	\$5,597,000	1,389	116
InnovAge (San Bernardino and Riverside)	\$20,186,000	4,785	399
Redwood Coast	\$5,284,000	1,527	127
Central Valley Medical Services	\$14,678,000	3,000	250
San Ysidro San Diego	\$4,192,000	935	78
Hope (San Bernardino and Riverside)	\$310,000	68	23
Total Capitation Payments	\$322,812,000	71,189	5,949
Total FY 2016-17	\$322,812,000		

*Totals may differ due to rounding.

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 116
 IMPLEMENTATION DATE: 7/2004
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 1029

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	\$144,027,000	\$147,449,000
- STATE FUNDS	\$56,425,140	\$58,233,990
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$144,027,000	\$147,449,000
STATE FUNDS	\$56,425,140	\$58,233,990
FEDERAL FUNDS	\$87,601,860	\$89,215,010

DESCRIPTION

Purpose:

The policy change estimates the cost of dental capitation rates for the Dental Managed Care (DMC) program.

Authority:

Social Security Act, Title XIX
 AB 82 (2013, Chapter 23), Section 14131.10 of the Welfare & Institutions Code

Interdependent Policy Changes:

Not Applicable

Background:

The DMC program provides a comprehensive approach to dental health care, combining clinical services and administrative procedures that are organized to provide timely access to primary care and other necessary services in a cost effective manner. The Department contracts with three Geographic Managed Care (GMC) plans and three Prepaid Health Plans (PHP). These plans provide dental services to Medi-Cal beneficiaries in Sacramento and Los Angeles counties.

Each dental plan receives a negotiated monthly per capita rate for every recipient enrolled in their plan. DMC program recipients enrolled in contracting plans are entitled to receive dental benefits from dentists within the plan's provider network.

AB 82 restored partial adult optional dental benefits, including full mouth dentures. Effective May 1, 2014, the scope of covered adult dental services offered at any dental service-rendering location that serves Medi-Cal beneficiaries, including FQHCs and RHCs, is limited to the adult optional benefits restored May 1, 2014, in addition to the adult dental benefits which include services for pregnant women, emergency services, FRADs, services provided at an Intermediate Care Facility/Skilled Nursing Facility, and services for Department of Developmental Services consumers. The impact of the restoration of adult dental benefits is included in the capitation rates.

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 116

Reason for Change from Prior Estimate:

The changes are due to updated monthly eligibles and dental rates for FY 2015-16 and FY 2016-17.

Methodology:

1. Effective July 1, 2009, separate dental managed care rates have been established for those enrollees under age 21. Beginning March 2011, these rates are paid on an ongoing basis.
2. The retroactive adjustments of the rates for FY 2013-14 and FY 2014-15 are shown in the Dental Retroactive Rate Changes policy change.
3. Rate adjustments have been included for FY 2014-15. These approved rates have been used for FY 2015-16. Proposed FY 2015-16 capitated rates have been used for FY 2016-17. FY 2015-16 rates include the exemption from AB 97.
4. The impact of the Restoration of Adult Dental Benefits is \$23,865,000 for FY 2015-16 and \$17,247,000 for FY 2016-17.
5. The impact of the Health Insurance Provider Fund (HIPF) is \$850,000 for FY 2016-17.

(Dollars in Thousands)

FY 2015-16	Capitation Rate	Average Monthly Eligibles	Total Funds
GMC			
<21	\$11.45	228,283	\$31,366
21+	\$8.42	157,776	\$15,942
PHP			
<21	\$12.95	318,631	\$49,515
21+	\$7.80	166,008	\$15,538
ACA Optional Dental			
GMC	\$8.42	353,817	\$2,979
PHP	\$7.80	3,603,835	\$28,110
ACA Mandatory Dental			
GMC 21+	\$8.42	1,143	\$9
GMC <21	\$11.45	3,324	\$38
PHP 21+	\$7.80	11,642	\$91
PHP <21	\$12.95	33,861	\$439
		Total FY 2015-16	\$144,027

DENTAL MANAGED CARE (Other M/C)

BASE POLICY CHANGE NUMBER: 116

(Dollars in Thousands)

FY 2016-17	Capitation Rate	Average Monthly Eligible	Total Funds
GMC			
<21	\$11.45	232,076	\$31,887
21+	\$8.42	160,398	\$16,207
PHP			
<21	\$12.95	319,770	\$49,692
21+	\$7.80	166,602	\$15,594
ACA Optional Dental			
GMC	\$8.42	366,943	\$3,090
PHP	\$7.80	3,737,529	\$29,153
ACA Mandatory Dental			
GMC 21+	\$8.42	1,934	\$16
GMC <21	\$11.45	5,625	\$64
PHP 21+	\$7.80	19,699	\$154
PHP <21	\$12.95	57,294	\$742
HIPF			\$850
		Total FY 2016-17	\$147,449

Funding:

	TF	GF	FF
FY 2015-16			
65% Title XIX / 35% GF 4260-101-0001/0890	\$34,000	\$12,000	\$22,000
88% Title XIX / 12% GF 4260-101-0001/0890	\$102,000	\$12,000	\$90,000
50% Title XIX / 50% GF 4260-101-0001/0890	\$112,802,000	\$56,401,000	\$56,401,000
100% Title XIX ACA FF 4260-101-0890	\$31,089,000	\$0	\$31,089,000
Total	\$144,027,000	\$56,425,000	\$87,602,000
FY 2016-17			
88% Title XIX / 12% GF 4260-101-0001/0890	\$232,000	\$28,000	\$204,000
50% Title XIX / 50% GF 4260-101-0001/0890	\$114,791,000	\$57,395,000	\$57,396,000
100% Title XIX ACA FF 4260-101-0890	\$16,213,000	\$0	\$16,213,000
95% Title XIX ACA FF / 5% GF 4260-101-0001/0890	\$16,213,000	\$811,000	\$15,402,000
Total	\$147,449,000	\$58,234,000	\$89,215,000

*Totals may differ due to rounding.

SENIOR CARE ACTION NETWORK (Other M/C)

BASE POLICY CHANGE NUMBER: 117
 IMPLEMENTATION DATE: 2/1985
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 61

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$60,948,000	\$74,169,000
- STATE FUNDS	\$30,474,000	\$37,084,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$60,948,000	\$74,169,000
STATE FUNDS	\$30,474,000	\$37,084,500
FEDERAL FUNDS	\$30,474,000	\$37,084,500

DESCRIPTION

Purpose:

This policy change estimates the capitated payments associated with enrollment of dual eligible Medicare/Medi-Cal beneficiaries in the Senior Care Action Network (SCAN) health plan.

Authority:

Welfare & Institutions Code 14200

Interdependent Policy Changes:

PC 111 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 129 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 130 MCO Tax Managed Care Plans

Background:

SCAN is a Medicare Advantage Special Needs Plan and contracts with the Department to coordinate and provide health care services on a capitated basis for persons aged 65 and older with both Medicare and Medi-Cal coverage in Los Angeles, San Bernardino, and Riverside Counties. Enrollees who are certified for Skilled Nursing Facility (SNF) and Intermediate Care Facility (ICF) level of care are eligible for additional Home and Community Based Services (HCBS) through the SCAN Health Plan Independent Living Power program.

Reason for Change from Prior Estimate:

Eligible months were updated with actuals from January 2015 through July 2015 and increased by 34% for FY 2015-16 and 21% for FY 2016-17. The changes are also due to delayed implementation of 2015 SCAN rates and calendar year (CY) 2014 rate update to incorporate adult dental benefit restoration for the period of May through December 2014.

Methodology:

1. Estimated SCAN costs are computed by multiplying the actual and estimated monthly eligible count for each county by the capitated rates for each county and beneficiary type – Aged and Disabled or Long-Term Care.

SENIOR CARE ACTION NETWORK (Other M/C)

BASE POLICY CHANGE NUMBER: 117

2. Total enrollment is projected to be 12,915 in December 2015 and 14,064 by June 2016 based on Medi-Cal enrollment projections submitted by SCAN.
3. The CY 2014 rates for dually eligible enrollees were determined using SCAN provided costs for Medi-Cal services rendered to this population. The rates for CY 2015 and 2016 have not been finalized. The Department is finalizing CY 2015 rates using SCAN actuals. CY 2016 rates are projected by trending forward from preliminary CY 2015 rates. Rates in development will be based on SCAN plans' actual experience.
4. The Department anticipates receiving CMS approval in September 2015 for contract amendments implementing recalculated SCAN 2014 rates for the period of May 2014 through December 2014, reflecting the restoration of the adult dental benefit. This will result in a repayment to SCAN of approximately \$445,000 for capitation payments made from May 2014 through December 2014 using updated SCAN CY 2014 rates. The repayment is expected to occur during the October 2015 capitation cycle.
5. The Department anticipates receiving CMS approval of contract amendments implementing 2015 SCAN rates, retroactive from January 1, 2015, in November 2015. This will result in an estimated repayment of approximately \$3,820,000 for the increase in rates for SCAN health plans. The repayment is expected to occur during the December 2015 capitation cycle. This will also result in an estimated recoupment of approximately \$1,240,000 for the decrease to the rates set for SCAN health plans. The recoupment is expected to occur during the December 2015 capitation cycle.

FY 2015-16	Costs	Eligible Months	Avg. Monthly Enrollment
Los Angeles	\$38,873,000	103,665	8,639
Riverside	\$12,365,000	29,240	2,437
San Bernardino	\$7,857,000	19,571	1,631
Total	\$59,095,000	152,476	12,707
2014 Rate Repayment	\$445,000		
2015 Rate Repayment	\$2,084,000		
2015 Rate Recoupment	(\$676,000)		
Total FY 2015-16	\$60,948,000		
FY 2016-17	Costs	Eligible Months	Avg. Monthly Enrollment
Los Angeles	\$48,789,000	125,179	10,432
Riverside	\$15,520,000	35,310	2,943
San Bernardino	\$9,860,000	23,630	1,969
Total FY 2016-17	\$74,169,000	184,119	15,344

*Totals may differ due to rounding.

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)

AIDS HEALTHCARE CENTERS (Other M/C)

BASE POLICY CHANGE NUMBER: 120
 IMPLEMENTATION DATE: 5/1985
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 63

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$7,405,000	\$7,405,000
- STATE FUNDS	\$3,702,500	\$3,702,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$7,405,000	\$7,405,000
STATE FUNDS	\$3,702,500	\$3,702,500
FEDERAL FUNDS	\$3,702,500	\$3,702,500

DESCRIPTION

Purpose:

This policy change estimates the cost of capitation rates and the savings sharing for AIDS Healthcare centers.

Authority:

Welfare & Institutions Code 14088.85

Interdependent Policy Changes:

PC 111 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 129 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 130 MCO Tax Managed Care Plans

Background:

The HIV/AIDS capitated case management project in Los Angeles became operational in April 1995 and is currently the only remaining traditional Primary Care Case Management (PCCM) program. The Department has a contract with AIDS Healthcare Centers as a PCCM plan and participates in a program savings sharing agreement. On August 2, 2012, AIDS Healthcare Foundation received full-risk licensure. However, the contract with the Department has not been changed, and shared savings are expected to be produced by the PCCM's effective case management of services for which the PCCM is not at risk. The Department determined there were no shared savings for calendar year (CY) 2009. The shared savings for CY 2010, CY 2011, CY 2012 and beyond have not yet been determined. The Department entered into a five year contract with AIDS Healthcare Foundation effective January 1, 2012, through December 31, 2016. The Department expects to extend the contract beyond 2016.

Currently, the PCCM is receiving capitation payments at the 2011 capitation rate level through 2016. This has resulted in an overpayment to the PCCM given a reduction in capitation rates in 2012. The Department has a contractual option to recoup the overpayments on a monthly basis, retroactive to January 2012. Recoupment is expected to begin FY 2015-16.

AIDS HEALTHCARE CENTERS (Other M/C)

BASE POLICY CHANGE NUMBER: 120

AB 1422 (Chapter 157, Statutes of 2009) imposed a Gross Premium Tax on the total operating revenue of the Medi-Cal Managed Care plans. The proceeds from the tax were used to offset the capitation rates. ABX1 21 extended the gross premium tax through June 30, 2012. SB 78 extended the 2.35% gross premium tax through June 30, 2013, and imposed a 3.9375% statewide tax on managed care health plans effective July 1, 2013, through July 1, 2016.

Capitation rate increases due to the gross premium tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from the gross premium tax fund on a quarterly basis. The reimbursement is budgeted in the MCO Tax Managed Care Plans – Funding Adjustment policy change.

Reason for Change from Prior Estimate:

Recoupment of retroactive rate adjustments has been delayed from FY 2014-15 to FY 2015-16. Projected eligibles for FY 2015-16 and FY 2016-17 increased.

Methodology:

- 1) Assume dual eligible months will be 4,404 in FY 2015-16 and FY 2016-17.
- 2) Assume dual eligible monthly capitation rates are \$292.07 in FY 2015-16 and FY 2016-17.

Duals: FY 2015-16 and FY 2016-17: 4,404 x \$292.07 = **\$1,286,000 TF**

- 3) Assume Medi-Cal only eligible months will be 5,628 in FY 2015-16 and FY 2016-17.
- 4) Assume Medi-Cal only monthly capitation rates are \$1,502.07 in FY 2015-16 and FY 2016-17.

Medi-Cal Only: FY 2015-16 and FY 2016-17: 5,628 x \$1,502.07 = **\$8,454,000 TF**

- 5) The total recoupment for calendar years 2012 and 2013 is estimated to be **\$2,335,000 TF** in FY 2015-16 and FY 2016-17.

FY 2015-16	TF	GF	FF
Dual	\$1,286,000	\$643,000	\$643,000
Medi-Cal Only	\$8,454,000	\$4,227,000	\$4,227,000
Recoupment	(\$2,335,000)	(\$1,167,500)	(\$1,167,500)
Total	\$7,405,000	\$3,702,500	\$3,702,500

FY 2016-17	TF	GF	FF
Dual	\$1,286,000	\$643,000	\$643,000
Medi-Cal Only	\$8,454,000	\$4,227,000	\$4,227,000
Recoupment	(\$2,335,000)	(\$1,167,500)	(\$1,167,500)
Total	\$7,405,000	\$3,702,500	\$3,702,500

Funding:

50% Title XIX FF / 50% GF (4260-101-0001/0890)

FAMILY MOSAIC CAPITATED CASE MGMT. (Oth. M/C)

BASE POLICY CHANGE NUMBER: 122
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 66

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$913,000	\$913,000
- STATE FUNDS	\$456,500	\$456,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$913,000	\$913,000
STATE FUNDS	\$456,500	\$456,500
FEDERAL FUNDS	\$456,500	\$456,500

DESCRIPTION

Purpose:

This policy change estimates the cost of the contract with the Family Mosaic project.

Authority:

Welfare & Institutions Code 14087.3

Interdependent Policy Changes:

PC 111 MCO Tax Mgd. Care Plans – Incr. Cap. Rates
 PC 129 MCO Tax Mgd. Care Plans – Funding Adjustment
 PC 130 MCO Tax Managed Care Plans

Background:

The Department's contract with the Family Mosaic Project was effective January 1, 2008. The Family Mosaic Project, located in San Francisco, case manages emotionally disturbed children at risk for out-of-home placement. The contract with the Family Mosaic project has been extended through June 30, 2016. The Department anticipates continuing this agreement with Family Mosaic.

Reason for Change from Previous Estimate:

Based on actual 2015 enrollment, the estimated number of member months decreased from 535 to 494 in FY 2015-16 and FY 2016-17.

Methodology:

- 1) Assume the total member months will be 494 in FY 2015-16 and FY 2016-17.
- 2) The Family Mosaic capitation rates are assumed to be \$1,848.75 in FY 2015-16 and FY 2016-17.
- 3) The costs for the Family Mosaic Project are expected to be:
 FY 2015-16 and FY 2016-17: $494 \times \$1,848.75 = \mathbf{\$913,000 \text{ TF } (\$456,500 \text{ GF})}$

Funding:

50% Title XIX FF / 50% GF (4260-101-0001/0890)

MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS

BASE POLICY CHANGE NUMBER: 164
 IMPLEMENTATION DATE: 7/1988
 ANALYST: Humei Wang
 FISCAL REFERENCE NUMBER: 76

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$2,649,830,000	\$2,703,855,000
- STATE FUNDS	\$1,431,143,000	\$1,459,984,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,649,830,000	\$2,703,855,000
STATE FUNDS	\$1,431,143,000	\$1,459,984,500
FEDERAL FUNDS	\$1,218,687,000	\$1,243,870,500

DESCRIPTION

Purpose:

This policy change estimates Medi-Cal's expenditures for Medicare Part A and Part B premiums.

Authority:

Title 22, California Code of Regulations 50777
 Social Security Act 1843

Interdependent Policy Changes:

PC 134 Medicare Part B Premium Increase

Background:

This policy change estimates the costs for Part A and Part B premiums for Medi-Cal eligibles that are also eligible for Medicare coverage.

Reason for Change from Prior Estimate:

Increase is due to changes in estimated eligibles and the updated Part A premium. Projected Part B premium increase is in the Medicare Part B Premium Increase Policy Change.

	2015	2016		2017
	Actual	May 2015 Estimate	November 2015 Estimate	November 2015 Estimate
	Premiums			
Part A	\$407.00	\$ 407.00	\$411.00	\$ 415.04
Part B	\$104.90	\$ 104.90	\$104.90	\$ 104.90
	Average Monthly Eligibles			
Part A		178,700	178,400	181,200
Part B		1,325,400	1,338,100	1,367,800

MEDICARE PMNTS.- BUY-IN PART A & B PREMIUMS

BASE POLICY CHANGE NUMBER: 164

Methodology:

1. This policy change also includes adjustments due to reconciliations of state and federal data.
2. The Centers for Medicare and Medicaid set the 2015 Medicare Part A premium at \$407.00 and the Medicare Part B premium at \$104.90.
3. The Centers for Medicare and Medicaid set the 2016 Medicare Part A premium at \$411.00 and the Medicare Part B premium is budgeted at \$104.90.
4. For 2017, the Medicare Part A premium is estimated to increase by \$4.04 to \$415.04 based on its 2016 growth rate 0.0098, and the Medicare Part B premium is budgeted at \$104.90.
5. Medicare Part B premium is expected to increase in 2017 and is estimated in the Regular Policy Change – Medicare Part B Premium Increase.

FY 2015-16	Part A	Part B
Average Monthly Eligibles	178,400	1,338,100
Rate 07/2015-12/2015	\$407.00	\$104.90
Rate 01/2016-06/2016	\$411.00	\$104.90
FY 2016-17		
Average Monthly Eligibles	181,200	1,367,800
Rate 07/2016-12/2016	\$411.00	\$104.90
Rate 01/2017-06/2017	\$415.04	\$104.90

Funding:

100% GF (4260-101-0001)
 100% Title XIX (4260-101-0890)
 50% Title XIX / 50% GF (4260-101-0001/0890)

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER: 165
 IMPLEMENTATION DATE: 1/2006
 ANALYST: Peter Bjorkman
 FISCAL REFERENCE NUMBER: 1019

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	\$1,661,965,000	\$1,871,377,000
- STATE FUNDS	\$1,661,965,000	\$1,871,377,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,661,965,000	\$1,871,377,000
STATE FUNDS	\$1,661,965,000	\$1,871,377,000
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates Medi-Cal's Medicare Part D expenditures.

Authority:

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003

Interdependent Policy Changes:

Not Applicable

Background:

On January 1, 2006, Medicare's Part D benefit began. Part D provides a prescription drug benefit to all dual eligible beneficiaries and other Medicare eligible beneficiaries that enroll in Part D. Dual eligible beneficiaries had previously received drug benefits through Medi-Cal.

To help pay for this benefit, the federal government requires the states to contribute part of their savings for no longer providing the drug benefit to dual eligible beneficiaries. This is called the Phased-down Contribution or "clawback". In 2006, states were required to contribute 90% of their savings. This percentage decreases by 1 ²/₃% each year until it reaches 75% in 2015. The MMA of 2003 sets forth a formula to determine a state's "savings". The formula uses 2003 as a base year for states' dual eligible population drug expenditures and increases the average dual eligible drug costs by a growth factor to reach an average monthly phased-down contribution cost per dual eligible or the per member per month (PMPM) rate.

Medi-Cal's Part D Per Member Per Month (PMPM) rate:

<u>Calendar Year</u>	<u>PMPM rate</u>
2013	\$103.70
2014	\$97.40
2015	\$98.76
2016	\$110.23
2017	\$117.25 (estimated)

MEDICARE PAYMENTS - PART D PHASED-DOWN

BASE POLICY CHANGE NUMBER: 165

Medi-Cal's total payments on a cash basis and average monthly eligible beneficiaries by fiscal year:

Fiscal Year	Total Payment	Ave. Monthly Beneficiaries
FY 2012-13	\$1,454,929,918	1,176,313
FY 2013-14	\$1,479,580,071	1,213,682
FY 2014-15	\$1,522,511,847	1,296,510

Reason for Change from Prior Estimate:

- The projected average monthly eligibles have increased since the May Estimate.

Methodology:

- The 2015 growth increased 3.64% over 2014 amounts per *Centers for Medicare & Medicaid Services*. Medi-Cal's PMPM for 2015 is \$98.76.
- The 2016 growth increased 11.61% over 2015 amounts per *Centers for Medicare & Medicaid Services*. Medi-Cal's PMPM for 2016 is \$110.23.
- The 2017 growth is estimated to increase 6.37% based on the Part D 2015 annual percentage increase from *Centers for Medicare & Medicaid Services*. Medi-Cal's estimated PMPM for 2017 is \$117.25.
- Phase-down payments have a two-month lag (i.e., bills submitted in January are received in February and due in March).
- The average monthly eligible beneficiaries are estimated using the growth trend in the monthly Part D enrollment data from July 2010 – August 2015.
- The Phased-down Contribution is funded 100% by State General Fund.

	<u>Payment Months</u>	<u>Est. Ave. Monthly Beneficiaries</u>	<u>Est. Ave. Monthly Cost</u>	<u>Total Cost</u>
FY 2015-16	12	1,349,649	\$138,497,059	\$1,661,965,000
FY 2016-17	12	1,385,101	\$155,948,066	\$1,871,377,000

Funding:

100% GF (4260-101-0001)

HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)

BASE POLICY CHANGE NUMBER: 166
 IMPLEMENTATION DATE: 7/1990
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 23

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$1,708,743,000	\$1,535,667,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,708,743,000	\$1,535,667,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,708,743,000	\$1,535,667,000

DESCRIPTION

Purpose:

This policy change estimates the federal match for the California Department of Developmental Services (CDDS) for the Home & Community Based Services (HCBS) program.

Authority:

Interagency Agreement 01-15834

Interdependent Policy Changes:

Not Applicable

Background:

CDDS, under a federal HCBS waiver, offers and arranges for non-State Plan Medicaid services via the Regional Center system. The HCBS waiver allows the State to offer these services as medical assistance to individuals who would otherwise require the level of care provided in a hospital, nursing facility (NF), or in an intermediate care facility for the developmentally disabled (ICF/DD). Services include home health aide services, habilitation, transportation, communication aides, family training, homemaker/chore services, nutritional consultation, specialized medical equipment/supplies, respite care, personal emergency response system, crisis intervention, supported employment and living services, home and vehicle modifications, prevocational services, skilled nursing, residential services, specialized therapeutic services, and transition/set-up expenses.

While the General Fund for this waiver is in the CDDS budget on an accrual basis, the federal funds in the Department's budget are on a cash basis.

Reason for Change from Prior Estimate:

The estimated amounts for FY 2015-16 have increased from the 2015 Budget Act to include retroactive payments from prior years. There are fewer retroactive payments in FY 2016-17.

HOME & COMMUNITY-BASED SVCS.-CDDS (Misc.)

BASE POLICY CHANGE NUMBER: 166

Methodology:

The following estimates, on a cash basis, were provided by CDDS:

(Dollars in Thousands)	Total	CDDS	DHCS
	Funds	GF	FFP
FY 2015-16	\$3,417,486	\$1,708,743	\$1,708,743
FY 2016-17	\$3,071,333	\$1,535,666	\$1,535,667

Funding:

Title XIX 100% FFP (4260-101-0890)

DENTAL SERVICES

BASE POLICY CHANGE NUMBER: 167
 IMPLEMENTATION DATE: 7/1988
 ANALYST: Sandra Bannerman
 FISCAL REFERENCE NUMBER: 135

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	\$1,014,022,000	\$1,140,954,000
- STATE FUNDS	\$353,380,390	\$399,895,170
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,014,022,000	\$1,140,954,000
STATE FUNDS	\$353,380,390	\$399,895,170
FEDERAL FUNDS	\$660,641,610	\$741,058,830

DESCRIPTION

Purpose:

The policy change estimates the cost of dental services provided by Delta Dental.

Authority:

Social Security Act, Title XIX
 AB 82 (2013, Chapter 23), Section 14131.10 of the Welfare & Institutions Code

Interdependent Policy Changes:

Not Applicable

Background:

Delta Dental (Delta) has an at-risk contract to provide dental services to most Medi-Cal beneficiaries at a prepaid capitated rate per eligible. These dental costs are for fee-for-service (FFS) Medi-Cal beneficiaries. Dental costs for beneficiaries with dental managed care plans are shown in the Dental Managed Care policy change.

AB 82 restored partial adult optional dental benefits, including full mouth dentures. Effective May 1, 2014, the scope of covered adult dental services offered at any dental service-rendering location that serves Medi-Cal beneficiaries, including FQHCs and RHCs, is limited to the adult optional benefits restored May 1, 2014, in addition to adult dental benefits which include services for pregnant women, emergency services, FRADs, services provided at an Intermediate Care Facility/Skilled Nursing Facility, and services for Department of Developmental Services consumers. The restoration of adult dental benefits is included in the capitation rates.

The Department will no longer apply the annual \$1,800 beneficiary limit as a hard cap for dental services. If a beneficiary exceeds the \$1,800 limit, the Department will authorize the dental fiscal intermediary to override the \$1,800 limit so long as medical necessity is documented appropriately and/or a Treatment Authorization Request is submitted and approved in accordance with the dental Manual of Criteria. The capitation rates include the impact of implementing the change to \$1,800 soft cap.

DENTAL SERVICES

BASE POLICY CHANGE NUMBER: 167

Reason for Change from Prior Estimate:

The changes are due to updated monthly eligibles and dental rates for FY 2015-16 and FY 2016-17.

Methodology:

1. The approved FY 2014-15 capitation rates used for FY 2015-16 are \$7.81 for regular eligibles and \$5.81 for refugees.
2. The proposed FY 2015-16 capitation rates have been used for FY 2016-17 and now includes one rate for regular eligibles and refugees. FY 2015-16 rates include the exemption from AB 97.
3. The contractor is required to have an annual independent audit which includes the determination of any underwriting gain or loss. The audit for the period ending June 30, 2014 resulted in an underwriting gain of \$57.7 million. According to the contract distribution provisions, the Department will receive \$53 million and Delta will retain \$4.7 million in FY 2015-16.
4. The impact of the Restoration of Adult Dental Benefits is \$189,459,000 for FY 2015-16 and \$351,958,000 for FY 2016-17.
5. The impact of the Health Insurance Provider Fund (HIPF) is \$4,000,000 for FY 2016-17.

(Dollars in Thousands)

FY 2015-16	Rate	Average Monthly Eligibles	Total Funds
Regular 7/15 – 6/16	\$7.81	7,973,847	\$747,309
Refugee 7/15 – 6/16	\$5.81	1,339	\$93
Other FFS	Non-Capitated		\$84,788
		Subtotal	\$832,190
Underwriting Gain			(\$53,057)
		Total	\$779,133
ACA			
ACA Optional Dental	\$7.81	2,475,042	\$231,961
ACA Mandatory Dental	\$7.81	31,251	\$2,928
ACA Subtotal			\$234,889
		Total FY 2015-16	\$1,014,022

DENTAL SERVICES

BASE POLICY CHANGE NUMBER: 167

(Dollars in Thousands)

FY 2016-17	Rate	Average Monthly Eligibles	Total Funds
			Regular 7/15 – 6/16
Other FFS	Non-Capitated		\$88,863
		Subtotal	\$879,801
HIPF			\$4,000
ACA			
ACA Optional Dental	\$8.18	2,566,860	\$251,963
ACA Mandatory Dental	\$8.18	52,877	\$5,190
ACA Subtotal (included in dollars above)			\$257,153
Restoration of AB97			\$105,065
		Total FY 2016-17	\$1,140,954

Funding:

FY 2015-16	TF	GF	FF
65% Title XXI / 35% GF (4260-113-0001/0890)	\$29,111,000	\$10,189,000	\$18,922,000
88% Title XXI / 12% GF (4260-113-0001/0890)	\$87,332,000	\$10,480,000	\$76,852,000
65% Title XIX / 35% GF (4260-101-0001/0890)	\$682,000	\$239,000	\$443,000
100% GF (4260-101-0001)	\$10,000	\$10,000	\$0
50% Title XIX / 50% GF (4260-101-0001/0890)	\$664,926,000	\$332,463,000	\$332,463,000
100% Title XIX ACA (4260-101-0890)	\$231,961,000	\$0	\$231,961,000
95% Title XIX ACA FF / 5% GF (4260-101-0001/0890)	\$0	\$0	\$0
Total	\$1,014,022,000	\$353,381,000	\$660,641,000
FY 2016-17	TF	GF	FF
88% Title XXI / 12% GF (4260-113-0001/0890)	\$132,546,000	\$15,905,000	\$116,640,000
65% Title XIX / 35% GF (4260-101-0001/0890)	\$682,000	\$239,000	\$443,000
100% GF (4260-101-0001)	\$10,000	\$10,000	\$0
50% Title XIX / 50% GF (4260-101-0001/0890)	\$754,838,000	\$377,419,000	\$377,419,000
100% Title XIX ACA (4260-101-0890)	\$126,439,000	\$0	\$126,439,000
95% Title XIX ACA FF / 5% GF (4260-101-0001/0890)	\$126,439,000	\$6,322,000	\$120,117,000
Total	\$1,140,954,000	\$399,895,000	\$741,059,000

*Totals may differ due to rounding.

PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 168
 IMPLEMENTATION DATE: 4/1993
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 22

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$1,086,867,000	\$1,493,950,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,086,867,000	\$1,493,950,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,086,867,000	\$1,493,950,000

DESCRIPTION

Purpose:

This policy change provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS) for Medi-Cal beneficiaries participating in the In-Home Supportive Services (IHSS) programs: the Personal Care Services Program (PCSP) and the IHSS Plus Option (IPO) program administered by CDSS.

Authority:

Interagency Agreements:

03-75676 (PCSP)

09-86307 (IPO)

SB 1036 (Chapter 45, Statutes of 2012)

SB 1008 (Chapter 33, Statutes of 2012)

Interdependent Policy Changes:

Not Applicable

Background:

Eligible services are authorized under Title XIX of the federal Social Security Act (42 U.S.C., Section 1396, et. seq.). The Department draws down and provides FFP to CDSS via interagency agreements for the IHSS PCSP and the IPO program.

SB 1008 enacted the Coordinated Care Initiative which requires, in part, to mandatorily enroll dual eligibles into managed care for their Medi-Cal benefits. Those benefits include IHSS; see policy change CCI-Managed Care Payments for more information. IHSS costs are currently budgeted in this policy change, but due to the transition of IHSS recipients to managed care, some IHSS costs have been paid through managed care capitation beginning April 1, 2014. IHSS cost related to the recipients transitioning to managed care are budgeted in the CCI-Managed Care Payments policy change.

FFP for the county cost of administering the PCSP is in the Personal Care Services policy change located in the Other Administration section of the Estimate.

PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 168

Reason for Change from Prior Estimate:

Revised expenditure data is provided by CDSS.

Methodology:

1) The following estimates were provided by CDSS on a cash basis.

(Dollars in Thousands)

	TF	FFP	CDSS GF/ County Share
FY 2015-16	\$2,173,734	\$1,086,867	\$1,086,867
FY 2016-17	\$2,987,900	\$1,493,950	\$1,493,950

Funding:

Title XIX 100% FFP (4260-101-0890)

DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

BASE POLICY CHANGE NUMBER: 169
 IMPLEMENTATION DATE: 7/1997
 ANALYST: Jason Moody
 FISCAL REFERENCE NUMBER: 77

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$206,129,000	\$207,330,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$206,129,000	\$207,330,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$206,129,000	\$207,330,000

DESCRIPTION

Purpose:

This policy change estimates the federal match provided to the California Department of Developmental Services (CDDS) for Developmental Centers (DCs) and State Operated Community Small Facilities (SOCFs).

Authority:

Interagency Agreement (IA) 03-75282
 IA 03-75283

Interdependent Policy Changes:

Not Applicable

Background:

The Department entered into an IA with CDDS to reimburse the Federal Financial Participation (FFP) for Medi-Cal clients served at DCs and SOCFs. There are four DCs and one SOCF statewide. The Budget Act of 2003 included the implementation of a quality assurance (QA) fee on the entire gross receipts of any intermediate care facility. DCs and SOCFs are licensed as intermediate care facilities. This policy change also includes reimbursement for the federal share of the QA fee.

The General Fund (GF) is included in the CDDS budget on an accrual basis and the federal funds in the Department's budget are on a cash basis.

Reason for Change from Prior Estimate:

The changes are due to updated expenditures.

DEVELOPMENTAL CENTERS/STATE OP SMALL FAC

BASE POLICY CHANGE NUMBER: 169

Methodology:

1. The following estimates have been provided by CDDS.

(Dollars in Thousands)

CASH BASIS	Total Funds	CDDS GF	FFP Regular
FY 2015-16	\$412,258	\$206,129	\$206,129
FY 2016-17	\$414,660	\$207,330	\$207,330

Funding:

100% Title XIX (4260-101-0890)

TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 171
 IMPLEMENTATION DATE: 7/1991
 ANALYST: Jason Moody
 FISCAL REFERENCE NUMBER: 26

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$188,380,000	\$161,949,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$188,380,000	\$161,949,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$188,380,000	\$161,949,000

DESCRIPTION

Purpose:

This policy change estimates the federal match for the California Department of Developmental Services (CDDS) for regional center targeted case management services provided to eligible developmentally disabled clients.

Authority:

Interagency Agreement (IA) 03-75284

Interdependent Policy Changes:

Not Applicable

Background:

Authorized by the Lanterman Act, the Department entered into an IA with CDDS to reimburse the Title XIX federal financial participation (FFP) for targeted case management services for Medi-Cal eligible clients. There are 21 CDDS Regional Centers statewide that provide these services. CDDS conducts a time study every three years and an annual administrative cost survey to determine each regional center's actual cost to provide Targeted Case Management (TCM). A unit of service reimbursement rate for each regional center is established annually. To obtain FFP, the federal government requires that the TCM rate be based on the regional center's cost of providing case management services to all of its consumers with developmental disabilities, regardless of whether the consumer is TCM eligible.

The General Fund is in the CDDS budget on an accrual basis. The federal funds in the Department's budget are on a cash basis.

Reason for Change from Prior Estimate:

The caseload has been updated.

TARGETED CASE MGMT. SVCS. - CDDS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 171

Methodology:

1. The following estimates have been provided by CDDS:

(Dollars in Thousands)

CASH BASIS	Total Fund	CDDS GF	DHCS FFP
FY 2015-16	\$376,761	\$188,381	\$188,380
FY 2016-17	\$323,898	\$161,949	\$161,949

Funding:

100% Title XIX (4260-101-0890)

MEDI-CAL TCM PROGRAM

BASE POLICY CHANGE NUMBER: 175
 IMPLEMENTATION DATE: 6/1995
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 27

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$43,872,000	\$39,634,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$43,872,000	\$39,634,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$43,872,000	\$39,634,000

DESCRIPTION

Purpose:

This policy change estimates the federal match provided to Local Government Agencies (LGAs) for the Targeted Case Management (TCM) program.

Authority:

SB 910 (Chapter 1179, Statutes of 1991), Welfare & Institutions Code 14132.44

Interdependent Policy Changes:

Not Applicable

Background:

The TCM program provides funding to LGAs for assisting Medi-Cal beneficiaries in gaining access to needed medical, social, educational, and other services. TCM services include needs assessment, individualized service plans, referral, and monitoring/follow-up. Through rates established in the annual cost reports, LGAs submit invoices to the Department to claim federal financial participation (FFP). The TCM program, per the approved State Plan Amendment (SPA) #10-010, serves children under 21, medically fragile individuals 18 and over, individuals at risk of institutionalization, individuals at risk of negative health or psycho-social outcomes, and individuals with communicable diseases.

Reason for Change from Prior Estimate:

The change is due to:

- A lower FY 2015-16 baseline estimate for claims,
- A lower annual percentage increase assumption from 2% to 1%,
- A lower estimate of the increased claims resulting from the SPA#10-010 removal of the capitated amount,
- A lower than previously estimated ACA encounter cost,
- Addition of FY 2014-15 remaining payments to be paid in FY 2015-16, and
- The inclusion of the FY 2010-11 reconciliation recoupment.

MEDI-CAL TCM PROGRAM

BASE POLICY CHANGE NUMBER: 175

Methodology:

1. SPA #10-010, approved on December 19, 2013, also lifted the annual capitated amount (CAP removal), effective October 16, 2010. The annual capitated amount is the maximum amount of dollars an LGA could claim for reimbursement within a target population.
2. The projected payment amount of \$38.721 million for FY 2015-16 and FY 2016-17 is based on average expenditures from FY 2013-14 through FY 2014-15.
3. Assume a 1% cost increase each year.
4. In FY 2015-16, \$1,315,000 will be paid for ACA encounters retro to January 1, 2014. In FY 2016-17, ACA encounters are estimated to be \$526,000.
5. In FY 2015-16, additional SPA cap removal claims will be paid for FY 2010-11 and FY 2012-13. Additionally, FY 2014-15 claims not paid in FY 2014-15 will be paid in FY 2015-16.
6. In FY 2015-16, the FY 2010-11 reconciliation will be completed and the Department will recoup \$3,609,000 and pay \$55,000, for a savings of \$3,554,000.
7. Assume the FY 2016-17 payment is the same as FY 2015-16 with an adjustment that includes an ACA Federal Medicaid Assistance Percentage decrease to 95% effective January 1, 2017.

FY 2015-16	FF
FY 2015-16 Base (Average Expenditures)	\$38,721,000
1% Program cost increase	\$387,000
SPA#10-010 increase (CAP removal)	
FY 2010-11	\$270,000
FY 2012-13	\$29,000
ACA encounters	
FY 2013-14	\$263,000
FY 2014-15	\$526,000
FY 2015-16	\$526,000
Additional claims	
FY 2014-15	\$6,704,000
Reconciliation	
FY 2010-11	(\$3,554,000)
Total FY 2015-16	\$43,872,000

FY 2016-17	FF
FY 2016-17 Base (Average Expenditures)	\$38,721,000
1% Program cost increase	\$387,000
ACA encounters	
FY 2016-17	\$526,000
Total FY 2016-17	\$39,634,000

MEDI-CAL TCM PROGRAM

BASE POLICY CHANGE NUMBER: 175

Funding:

100% Title XIX FFP (4260-101-0890)

100% Title XIX ACA (4260-101-0890)

95% Title XIX ACA (4260-101-0890)

WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 176
 IMPLEMENTATION DATE: 4/2000
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 32

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$40,250,000	\$41,545,000
- STATE FUNDS	\$20,125,000	\$20,772,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$40,250,000	\$41,545,000
STATE FUNDS	\$20,125,000	\$20,772,500
FEDERAL FUNDS	\$20,125,000	\$20,772,500

DESCRIPTION

Purpose:

This policy change estimates the costs associated with adding personal care services (PCS) to the Nursing Facility (NF) Waivers.

Authority:

AB 668 (Chapter 896, Statutes of 1998)
 Interagency Agreement (IA) 03-75898

Interdependent Policy Changes:

PC 39 California Community Transitions (CCT) Costs

Background:

AB 668 authorized additional hours on behalf of eligible PCS program recipients if they needed more than the monthly hours allowed under the In-Home Supportive Services Program (IHSS) and qualified for the Medi-Cal Skilled NF Level of Care Home and Community Based Services (HCBS) Waiver program. NF Level A/B, NF Subacute (SA), and In-Home Medical Care Waivers were merged into two waivers called the Nursing Facility/Acute Hospital (NF/AH) Waiver and the In-Home Operations (IHO) Waiver. These waivers provide HCBS to Medi-Cal eligible waiver participants using specific Level Of Care (LOC) criteria. Waiver Personal Care Services (WPCS) under these two waivers include services that differ from those in the State Plan which allow beneficiaries to remain at home. Although there is no longer a requirement that waiver consumers receive a maximum of 283 hours of IHSS prior to receiving WPCS, waiver consumers must first utilize authorized State Plan IHSS hours prior to accessing this waiver service. These services are provided by the counties' IHSS program providers and paid via an IA with the Department or will be provided by home health agencies and other qualified HCBS waiver provider types paid via the Medi-Cal fiscal intermediary.

Reason for Change from Prior Estimate:

The total hours were revised from the prior estimate, which were projected higher than usual. The FY 2015-16 rate has increased due to an increase in WPCS participants and all counties with provider rates under \$10/hour will increase to the \$10 minimum wage, effective January 1, 2016.

WAIVER PERSONAL CARE SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 176

Methodology:

1. Assume the number of current NF A/B LOC Waiver beneficiaries using WPCS is estimated to increase by an average of 6 per month in FY 2015-16 and FY 2016-17.
2. Assume the number of current NF SA LOC beneficiaries using Waiver PCS is estimated to stay the same in FY 2015-16 and FY 2016-17.
3. The Department's CCT Demonstration Project expects to transition 528 beneficiaries out of inpatient extended health care facilities in FY 2015-16, and 540 beneficiaries in FY 2016-17. Based on actual data from July 2014 through June 2015, 6% of the beneficiaries are expected to use WPCS.
4. The average cost/hour is \$10.63 for FY 2015-16 and \$10.70 FY 2016-17.
5. The chart below displays the estimate on an accrual basis.

FY 2015-16	Total Hours	Cost/Hour	TF	GF	FF
NF/AH Waiver					
NF A/B	2,400,118	\$10.63	\$25,513,249	\$12,756,625	\$12,756,625
NF S/A	1,240,197	\$10.63	\$13,183,293	\$6,591,646	\$6,591,646
IHOWaiver					
NF A/B	143,760	\$10.63	\$1,528,172	\$764,086	\$764,086
NF S/A	26,503	\$10.63	\$281,725	\$140,862	\$140,862
Total			\$40,506,438	\$20,253,219	\$20,253,219
FY 2016-17	Total Hours	Cost/Hour	TF	GF	FF
NF/AH Waiver					
NF A/B	2,470,379	\$10.70	\$26,433,059	\$13,216,529	\$13,216,529
NF S/A	1,261,427	\$10.70	\$13,497,264	\$6,748,632	\$6,748,632
IHOWaiver					
NF A/B	143,760	\$10.70	\$1,538,235	\$769,118	\$769,118
NF S/A	26,503	\$10.70	\$283,580	\$141,790	\$141,790
Total			\$41,752,138	\$20,876,069	\$20,876,069

6. The chart below is adjusted on a cash basis.

(Dollars in Thousands)	TF	GF	FF
FY 2015-16	\$40,250	\$20,125	\$20,125
FY 2016-17	\$41,545	\$20,773	\$20,773

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)

EPSDT SCREENS

BASE POLICY CHANGE NUMBER: 177
 IMPLEMENTATION DATE: 7/2001
 ANALYST: Peter Bjorkman
 FISCAL REFERENCE NUMBER: 136

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	\$38,271,000	\$38,271,000
- STATE FUNDS	\$18,747,150	\$18,747,150
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$38,271,000	\$38,271,000
STATE FUNDS	\$18,747,150	\$18,747,150
FEDERAL FUNDS	\$19,523,850	\$19,523,850

DESCRIPTION

Purpose:

This policy change estimates the screening costs for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

Authority:

Title 22, California Code of Regulations 51340(a)

Interdependent Policy Changes:

Not Applicable

Background:

The Child Health and Disability Prevention program is responsible for the screening component of the EPSDT benefit of the Medi-Cal program, including the health assessments, immunizations, and laboratory screening procedures for Medi-Cal children.

Reason for Change from Prior Estimate:

Nearly offsetting changes in the estimated number of screens and cost per screen result in a slightly lower projection of estimated expenditures.

Methodology:

Costs are determined by multiplying the number of screens by the estimated average cost per screen for FY 2015-16 and FY 2016-17, based on historical trends from July 2010 to April 2015.

FY 2015-16

Screens 642,990 x \$59.52 (weighted average) = **\$38,271,000** (rounded)

FY 2016-17

Screens 642,990 x \$59.52 (weighted average) = **\$38,271,000** (rounded)

EPSDT SCREENS

BASE POLICY CHANGE NUMBER: 177

Funding:

50% Title XIX / 50% GF (4260-101-0001/0890)

65% Title XXI / 35% GF (4260-113-0001/0890)

LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER: 183
 IMPLEMENTATION DATE: 7/1989
 ANALYST: Jason Moody
 FISCAL REFERENCE NUMBER: 93

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	\$3,370,000	\$1,865,000
- STATE FUNDS	\$1,707,000	\$932,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,370,000	\$1,865,000
STATE FUNDS	\$1,707,000	\$932,500
FEDERAL FUNDS	\$1,663,000	\$932,500

DESCRIPTION

Purpose:

This policy change estimates the cost of Medi-Cal lawsuit judgments, settlements, and attorney fees that are not shown in other policy changes.

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

State Legislature appropriates State dollars to pay the costs related to Medi-Cal lawsuits and claims. Larger lawsuit settlement amounts require both State Legislature and the Governor's approval for payment. Federal financial participation is claimed for all lawsuit settlements approved by the Legislature and the Governor.

Reason for Change from Prior Estimate:

Lawsuits were updated.

Methodology:

1. Attorney Fees

1. Shreve v. Kent	\$2,500
2. Terry L. Hibbs v. DHCS, et al.	\$5,000
Total for FY 2015-16	\$7,500

2. Provider Settlements of \$75,000 or Less Payments

1. Catholic HealthcareWest	\$5,406
2. CPH Hospital Management	\$1,265
3. CHA Hollywood Medical Center	\$24,552
4. Farrow Evan	\$536

LAWSUITS/CLAIMS

BASE POLICY CHANGE NUMBER: 183

5. Ramona Care v. L.A. Care and DHCS		\$75,000
6. LA County – Minor Consent Disallowance (100% GF)		\$43,693
Total for FY 2015-16		\$150,452
3. <u>Beneficiary</u>		
1. Shreve v. Kent		\$452
Total for FY 2015-16		\$452
4. <u>Other Attorney Fees Payments</u>		
1. California Association of Rural Health Clinics		\$325,000
2. Saavedra		\$475,000
3. ILC of Southern California v. Maxwell-Jolly		\$180,000
4. Desert Valley Hospital v. Toby Douglas, DHCS		\$500,000
Total for FY 2015-16		\$1,480,000
5. <u>Other Beneficiary Settlements</u>		
1. Victim's Compensation and Government Claims Board Claims		\$25,000
Total for FY 2015-16		\$25,000

	Committed	Balance	Budgeted	Budgeted
	2015-16	2015-16	2015-16	2016-17
Attorney Fees <\$5,000	\$7,500	\$42,500	\$50,000 *	\$50,000 *
Provider Settlements <\$75,000	\$150,452	\$1,449,548	\$1,600,000 *	\$1,600,000 *
Beneficiary Settlements <\$2,000	\$452	\$14,548	\$15,000 *	\$15,000 *
Small Claims Court	\$0	\$200,000	\$200,000 *	\$200,000 *
Other Attorney Fees	\$1,480,000	N/A	\$1,480,000	\$0
Other Provider Settlements	\$0	N/A	\$0	\$0
Other Beneficiary Settlements	\$25,000	N/A	\$25,000	\$0
	\$1,663,404	\$1,706,596	\$3,370,000	\$1,865,000

* Represents potential totals.

Funding:

50% GF / 50% Title XIX FFP (4260-101-0001/0890)

100% GF (4260-101-0001)

HIPP PREMIUM PAYOUTS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 184
 IMPLEMENTATION DATE: 1/1993
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 91

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$2,216,000	\$2,283,000
- STATE FUNDS	\$1,108,000	\$1,141,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,216,000	\$2,283,000
STATE FUNDS	\$1,108,000	\$1,141,500
FEDERAL FUNDS	\$1,108,000	\$1,141,500

DESCRIPTION

Purpose:

This policy change estimates the cost of the payouts for the Department's Health Insurance Premium Payment (HIPP) program.

Authority:

Welfare & Institutions Code 14124.91
 Social Security Act 1916(e)
 Title 22 California Code of Regulations 50778 (Chapter 2, Article 15)

Interdependent Policy Changes:

Not Applicable

Background:

The HIPP program is a voluntary program for full-scope Medi-Cal beneficiaries who have a high cost medical condition. The Centers for Medicare and Medicaid Services (CMS) approved a State Plan Amendment (SPA) allowing the Department to revise the methodology for determining cost effectiveness under the HIPP program. Effective July 1, 2014, in addition to premiums, the Department will also pay for coinsurance, deductibles, and other cost sharing obligations when it is cost effective. HIPP program costs are budgeted separately from other Medi-Cal benefits since these are paid outside of the regular Medi-Cal claims payment procedures.

Reason for Change from Prior Estimate:

Based on updated data, HIPP program expenditures increased and enrollment decreased resulting in higher average costs.

Methodology:

1. Premium costs are determined by the prior year's average premium expense and include ancillary costs as incurred.
2. In FY 2015-16 and FY 2016-17, it is estimated that there will be a decrease in enrollment and the insurance premiums will increase by 5% over the previous year.

HIPP PREMIUM PAYOUTS (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 184

3. The average monthly premium cost including ancillary costs is estimated to be \$686.47 in FY 2015-16 and \$720.79 in FY 2016-17.
4. The average monthly HIPP enrollment is estimated to be 269 in FY 2015-16 and 264 in FY 2016-17.
5. Costs for FY 2015-16 and FY 2016-17 are estimated to be:

FY2015-16: $\$686.47 \times 269 \times 12 \text{ Months} = \$2,216,000 \text{ TF } (\$1,108,000 \text{ GF})$

FY2016-17: $\$720.79 \times 264 \times 12 \text{ Months} = \$2,283,000 \text{ TF } (\$1,141,000 \text{ GF})$

Funding:

50% Title XIX FF/50% GF (4260-101-0001/0890)

CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 185
 IMPLEMENTATION DATE: 7/1997
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1083

	FY 2015-16	FY 2016-17
FULL YEAR COST - TOTAL FUNDS	\$1,537,000	\$1,028,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,537,000	\$1,028,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$1,537,000	\$1,028,000

DESCRIPTION

Purpose:

This policy change estimates the federal match provided to the California Department of Public Health (CDPH) for benefit costs associated with the Childhood Lead Poisoning Prevention (CLPP) Program.

Authority:

Interagency Agreement (IA) #07-65689

Interdependent Policy Changes:

Not Applicable

Background:

The CLPP Program provides case management services utilizing revenues collected from fees. County governments receive the CLPP revenues matched with the federal funds for case management services provided to Medi-Cal beneficiaries. The federal match is provided to CDPH through an Interagency Agreement.

Reason for Change from Prior Estimate:

There are still costs to be incurred in the current year due to delay in local jurisdictions invoicing to the State.

Methodology:

1. Annual expenditures on the accrual basis are \$2,056,000. Cash basis expenditures vary from year-to-year based on when claims are actually paid.
2. The estimates are provided by CDPH on a cash basis.

CLPP CASE MANAGEMENT SERVICES (Misc. Svcs.)

BASE POLICY CHANGE NUMBER: 185

(Dollars in Thousands)

FY 2015-16	DHCS FFP	CDPH CLPP Fee Funds
Benefits Costs	\$1,537	\$1,537

FY 2016-17	DHCS FFP	CDPH CLPP Fee Funds
Benefits Costs	\$1,028	\$1,028

Funding:

100% Title XIX FFP (4260-101-0890)

BASE RECOVERIES

BASE POLICY CHANGE NUMBER: 197
 IMPLEMENTATION DATE: 7/1987
 ANALYST: Stephanie Hockman
 FISCAL REFERENCE NUMBER: 127

	<u>FY 2015-16</u>	<u>FY 2016-17</u>
FULL YEAR COST - TOTAL FUNDS	-\$306,727,000	-\$289,203,000
- STATE FUNDS	-\$160,453,000	-\$151,286,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$306,727,000	-\$289,203,000
STATE FUNDS	-\$160,453,000	-\$151,286,000
FEDERAL FUNDS	-\$146,274,000	-\$137,917,000

DESCRIPTION

Purpose:

This policy change estimates estate, personal injury, and other insurance recoveries and provider/beneficiary overpayment used to offset the cost of Medi-Cal services.

Authority:

- Welfare & Institutions Code 14009, 14009.5, 14124.70–14124.795, 14124.88, 14124.90-14124.94, 14172, 14172.5, 14173, 14176, and 14177
- Probate Code Sections 215, 9202, 19202, 3600-3605, and 3610-3613
- Title 22, California Code of Regulations Chapter 2.5 and Sections 50781-50791, 51045, 51047, and 51458.1

Interdependent Policy Changes:

Not Applicable

Background:

Recoveries are credited to the Health Care Deposit Fund and used to finance current obligations of the Medi-Cal program. These recoveries result from collections from estates, personal injury settlements, judgements or awards, provider/beneficiary overpayments, and other health insurance to offset the cost of services to Medi-Cal beneficiaries in specified circumstances.

Reason for Change from Prior Estimate:

July 2015 provider audits were higher than average resulting in additional overpayment collections.

BASE RECOVERIES

BASE POLICY CHANGE NUMBER: 197

(Dollars in Thousands)

	FY 2015-16	FY 2016-17
Personal Injury Collections	(\$57,510)	(\$56,228)
Workers' Comp. Contract	(\$1,788)	(\$1,788)
H.I. Contingency Contract	(\$73,500)	(\$73,500)
General Collections	(\$173,928)	(\$157,686)
TOTAL	(\$306,727)	(\$289,203)

Methodology:

1. The recoveries estimate uses the trend in monthly recoveries for July 2012 – July 2015.
2. The General Fund ratio for collections is estimated to be 52.31% in FY 2015-16 and FY 2016-17.

Funding:

100% GF (4260-101-0001)

50% GF / 50% Title XIX (4260-101-0001/0890)